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EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID

1115 DEMONSTRATION WAIVER
ANNUAL REPORT
SFY 2005

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MassHealth 1115 Demonstration Project
Annual Report SFY2005

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Abbreviations

AHEC	Area Health Education Center
AIDS	Acquired Immunodeficiency Syndrome
ATS	Acute Treatment Services
BEI	Billing and Enrollment Intermediaries
BHP	Behavioral Health Program
BMC	Boston Medical Center
BSAS	Bureau of Substance Abuse
BSI	Bureau of Special Investigation
CAFAS	Child & Adolescent Functional Assessment Scale
CAHPS	Consumer Assessment of Health Plan Survey
CCRC	Continuing Care Retirement Community
CDR	Continuing Disability Review
CFFC	Coordinated Family Focused Care
CHCS	Center for Health Care Strategies
CHEC	Community Health Employment Connection
CHPR	Center for Health Policy and Research
CLAS	Culturally and Linguistically Appropriate Services
CLPPP	Child Lead Poisoning Prevention Program
CMR	Care Monitoring Registry
CMS	Center for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
CPU	Central Processing Unit
CSHCN	Children with Special Health Care Needs
CSM	Contract Status Meeting
CTR	Clinical Topic Review
DHCFP	Division of Health Care Finance and Policy
DHHS	Department of Health and Human Services
DMH	Department of Mental Health
DMR	Department of Mental Retardation
DOE	Department of Education
DOR	Department of Revenue
DPH	Department of Public Health
DSS	Department of Social Services
DTA	Department of Transitional Assistance
DUA	Division of Unemployment Assistance
DYS	Department of Youth Services
EAEDC	Emergency Assistance to Elderly, Disabled and Children
EBR	Employee Benefits Resources
ECS	Electronic Claims Services
ED	Emergency Department
EI	Early Intervention
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment

ESI	Employer Sponsored Insurance
FAP	MassHealth Family Assistance Program
FFY	Federal Fiscal Year
FFP	Federal Financial Participation
FPL	Federal Poverty Level
GPRA	Government Performance Results Act
HAN	Health Access Network
HBA	Health Benefit Advisor
HCFA	Health Care Finance Administration
HEDIS	Health Plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
ICM	Intensive Clinical Management
ICP	Individual Care Plan
IP	Insurance Partnership
ISA	Interagency Service Agreement
MA21	Massachusetts Eligibility Computer System
MAAGPAC	MassHealth Adolescent Anticipatory Guidance Public Awareness Campaign
MAP	MassHealth Access Project
MassPRO	Massachusetts Peer Review Organization
MBHP	Massachusetts Behavioral Health Partnership (the Partnership)
MBR	Medical Benefit Request
MCAAP	Massachusetts Chapter American Academy of Pediatrics
MCPAP	Massachusetts Child Psychiatric Access Project
MCO	Managed Care Organization
MDS	Minimum Data Set
M&E	Monitoring and Evaluation
MEC	MassHealth Enrollment Center
MEQC	Medicaid Eligibility Quality Control
MER	Medical Eligibility Review
MHA	Massachusetts Hospital Association
MHQP	Massachusetts Health Quality Partnership
MHSA	Massachusetts Housing Shelter Alliance
MHSPY	Mental Health Services Program for Youth
MIP	Massachusetts Immunization Program
MIT	Medical Interpreting Training
MMIS	Medicaid Management Information System
MMIG	Massachusetts Medicaid Infrastructure Grant
MMS	Massachusetts Medical Society
MSIS	Medicaid Statistical Information System
MSP	Medical Security Plan
NCQA	National Committee for Quality Assurance
NEP	Northeast Partnership
NHLBI	National Heart, Lung, and Blood Institute's
NHP	Neighborhood Health Plan

PCC	Primary Care Clinician
PCP	Primary Care Physician
PCG	Public Consulting Group
PIMS	Performance Improvement Management Services
PQIP	Perinatal Quality Improvement Project
QI	Quality Improvement
QIP	Quality Improvement Projects
QIS	Quality Improvement Specialist
RC	Rating Categories
REVS	Recipient Eligibility Verification System
RFR	Request for Responses
RID	Recipient identification
RLC	Recovery Learning Center
RNM	Regional Network Manager
RWJ	Robert Wood Johnson
SBHC	School Based Health Center
S-CHIP	State Children's Health Insurance Program
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SNC	Safety Net Care
SNCP	Safety Net Care Pool
SSI	Supplemental Security Income
SSTA	State-to-Sate Technical Assistance
STD	Sexually Transmitted Disease
SUMARC	Support Materials Review Committee
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability
TWWIIA	Ticket to Work and Work Incentives Improvement Act
UCP	Uncompensated Care Pool
WIC	Women Infants and Children

I. Executive Summary

The period from July 1, 2004 – June 30, 2005 marked the 8th year of the Massachusetts 1115 Demonstration Project (the Demonstration), and the 3rd year of the first 3-year extension of the waiver. This waiver year was dominated by increased efforts to enroll eligible Massachusetts residents into the program, as well as preparations and negotiations for the Demonstration's second waiver extension.

The Commonwealth's objectives entering the extension process were to: 1) preserve the elements of the waiver terms and conditions that provided for robust and innovative expansions, eligibility streamlining, maximizing private health insurance, and quality-driven service delivery models in the current MassHealth program and; 2) negotiate new terms and conditions that would support the broader Health Care Reform agenda that has emerged as a policy priority of the Governor and legislature.

On June 30, 2004 the Commonwealth submitted its request for a second three-year extension of the MassHealth Demonstration Project. During the first half of SFY 2005, the Commonwealth was involved in vigorous negotiations with CMS, culminating in the January 26, 2005 approval of the Demonstration for the extension period from July 1, 2005 through June 30, 2008.

The most important features of the terms and conditions approved for the extension period are:

- MassHealth coverage for base, 1902 (r)(2), and expansion populations remains intact.
- Full implementation of regulations at 42 CFR Part 438, including, but not limited to, the actuarial soundness requirement for establishing managed care capitation rates.
- Establishment of the Safety Net Care Pool (SNCP) for the purpose of reducing the rate of uninsurance in the Commonwealth. The SNCP will use a combination of demonstration savings and the Commonwealth's disproportionate share hospital allotment to pay for costs of the uninsured. Starting with the annual report for SFY 2005 (this document), the Commonwealth must include a section that details how the SNCP, which begins on July 1, 2006, will impact the rate of uninsurance in Massachusetts.
- A new requirement to conduct an evaluation of the impact of the demonstration program during the extension period. The Commonwealth fulfilled the CMS requirement to submit a draft evaluation design to CMS within 120 days from the extension award.

Additionally, the extension award included approvals of previously submitted waiver amendment requests to reinstate coverage for non-institutionalized persons under age 65 with HIV and incomes between 133-200% FPL, and to increase the enrollment cap for MassHealth Essential from 36,000 to a range from 36,000 to 44,000. The HIV reinstatement was effective July 1, 2004 and the Essential amendment was effective January 26, 2005.

Throughout this annual report, you will find a multi-pronged approach in SFY 2005 to identifying and expediting enrollment for the approximately 106,000[1]persons who are eligible, but not enrolled, in existing MassHealth programs. Roll-out of the Virtual Gateway, joint application for MassHealth and Uncompensated Care Pool (UCP) coverage, enhanced targeted outreach, and increased member and provider education all combined this year to reach eligible populations. This resulted in a 5.2% enrollment increase in the Demonstration for SFY 2005 compared with SFY 2004.

In SFY 2005 the Commonwealth implemented the first release of the Virtual Gateway in the Executive Office of Health and Human Services (EOHHS). This web portal, which is integrated with the overall www.Mass.Gov site, is a comprehensive streamlining of information and transactions relating to Health and Human Services. This release provides the tools for the public to inquire into eligibility for health and nutrition programs, and for providers to sign people up for the programs over the Internet, using one electronic form for nine different health and nutrition programs—including MassHealth, Food Stamps, WIC, and others. An annual series of releases is planned to further extend these capabilities.

Applications volume through the Virtual Gateway for MassHealth and UCP determinations increased steadily throughout the year. By the end of SFY 2005 the Virtual Gateway deployment had reached provider sites constituting 80% of UCP volume. There are currently 120 MassHealth providers using the Virtual Gateway, made up of 72 hospitals and 48 community health centers.

This year, the Commonwealth continued to use the Massachusetts Behavioral Health Partnership contract as a vehicle to further integrate Primary Care Clinician (PCC) and behavioral health network management. Through this contract, MassHealth has improved care coordination across medical services and behavioral health services, strengthened the professional link between PCCs and behavioral health providers, and increased educational outreach for PCCs on behavioral health issues.

Both the PCC Plan and MassHealth's contracted managed care organizations (MCOs) continue to focus efforts on monitoring and improving quality. The Commonwealth monitors quality in its managed care programs through contract status meetings, member satisfaction surveys, HEDIS measures, and clinical topic reviews.

Overall, SFY 2005 was an active and important year in the MassHealth Demonstration Project. At the close of this year 863,816[2] individuals were enrolled in the MassHealth Demonstration. This represents a 55% increase in enrollment since the implementation

[1] Division of Health Care Finance and Policy's (DHCFP) *2004 Health Insurance Status of Massachusetts Residents Survey* estimated that there are 106, 000 individuals who are Medicaid eligible but unenrolled in the Massachusetts.

[2] These numbers include approximately 6,000 state-only funded, non-qualified alien MassHealth members enrolled in various eligibility groups.

of the Demonstration on July 1, 1997 and coverage for an additional 306,444 Massachusetts residents.

This SFY 2005 Annual Report reflects the final year of the Demonstration Project's first extension-- a period of growth and innovation despite intense budget challenges. This year the Commonwealth also ushers in the Demonstration's second extension period, offering new terms and conditions that will support a major public policy initiative in the Commonwealth to further reduce the number of uninsured.

II. Introduction

On April 12, 1994, the Commonwealth of Massachusetts submitted a request to the U.S. Department of Health and Human Services for approval of MassHealth, a five-year Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act. The former Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS), approved the waiver request on April 24, 1995, subject to a set of special terms and conditions establishing the nature, character, and extent of Federal involvement in the demonstration. The Commonwealth implemented the 1115 Demonstration in July 1997. In December 2001, CMS extended the waiver for an additional three years. SFY05 is the third year of a three-year extension.

In accordance with the special terms and conditions of the MassHealth Demonstration, this Annual Report describes activities in year eight of the Demonstration. The report highlights activities and developments undertaken in the areas of eligibility, outreach and marketing, enrollment in health plans, service delivery and access, Family Assistance and the Insurance Partnership, quality assurance, and the emerging Safety Net Care program.

III. Eligibility

As of June 30, 2005 the MassHealth Demonstration population total was 863,816[3] individuals, an increase of 5.2% from June 30, 2004 (see Table1). Since the beginning of the Demonstration there has been a 55% growth in the MassHealth Demonstration population (see Chart 1 in Appendix A).

These numbers, and all numbers within this section, include all children who receive MassHealth coverage through Standard, CommonHealth, or Family Assistance. Some of these children are eligible for and funded through the State Children's Health Insurance Program (SCHIP), which provides an enhanced rate of federal financial participation (FFP) through Title XXI. Through the combination of the 1115 demonstration and the Title XXI state plan, MassHealth provides coverage for all children at or below 200% FPL and disabled children of any income.

Eligibility by Coverage Types: The MassHealth Demonstration population is distributed across 6 coverage types, as well as the Medical Security Plan (MSP) which is operated by the Division of Unemployment Assistance (DUA) (see Chart 2 in Appendix A). Applicants are categorized by coverage type based on financial and categorical eligibility, and receive the most comprehensive coverage type for which they qualify. MassHealth's significant expansion of coverage for children is accomplished through a combination of the Demonstration Project Waiver and the SCHIP state plan.

Generally, the MassHealth Demonstration Project covers persons under the age of 65 who are not institutionalized or receiving Home and Community-based waiver services. The Demonstration does extend to persons aged 65 or older only if they are parents or caretaker relatives of children or if they are working disabled.

MassHealth Standard provides benefits to children under age 19 whose gross family income is at or below 150% of the FPL, the parents of children whose gross family income is at or below 133% FPL, pregnant women and children under age one whose gross family income is at or below 200% FPL, and non-institutionalized disabled individuals whose gross family income is at or below 133% FPL. MassHealth requires premiums for certain Standard children above the age of 6 whose family income is greater than 133% FPL. Additionally, Standard Disabled members who have family incomes above 114% FPL are required to pay a premium. For families, premiums are $12 per child per month, up to a $15 family maximum. For disabled members, premiums are $15 per family per month. MassHealth Standard members receive the full Title XIX benefits package. Benefits are generally provided either through contracted Managed Care Organizations (MCOs) or through the Primary Care Clinician (PCC) managed care plan administered by MassHealth. As of June 30, 2005, 720,203 individuals were enrolled in MassHealth Standard through the waiver, accounting for

[3] These numbers include approximately 6,000 state-only funded, non-qualified alien MassHealth members enrolled in various eligibility groups.

83% of the total Demonstration population. There was an increase of 13,126 members, or 1.9%, in MassHealth Standard between June 30, 2004 and June 30, 2005.

MassHealth CommonHealth provides benefits to disabled adults, both non-working and working, and disabled children who are not eligible for MassHealth Standard. There is no income limit for CommonHealth; however, non-working disabled adults are required to meet a one-time deductible before becoming eligible. CommonHealth members are required to pay a monthly premium based on family group income. The benefit package is very similar to that provided to members under Standard. On June 30,2005,15,567 individuals were enrolled in CommonHealth, representing 1.8% of the Demonstration population. There was an increase of 1,232 members between June 30, 2004 and June 30, 2005.

MassHealth Family Assistance provides benefits to children who are not eligible for Standard or CommonHealth, and whose gross family income is greater than 150% FPL, but not more than 200% FPL. These children receive premium assistance toward qualifying employer-sponsored health insurance, when such coverage is available. In certain cases, MassHealth also provides coverage for co-payments related to well-baby/well-child visits and other co-payments/deductibles after the out-of-pocket expenses for the children have exceeded 5% of the family's gross income. If there is no access to qualifying health insurance, children receive services through one of the MassHealth's managed-care plans. The benefits are similar to those provided under Standard, with the exception of non-emergency transportation, day habilitation services, and personal care services. Monthly premiums did not change in SFY 2005. They are $12 per child, with a maximum payment of $36 per family.

Family Assistance also provides premium assistance to certain adults who work for participating small employers and have family incomes at or below 200% of the FPL. Through the Insurance Partnership, in addition to making premium assistance payments, MassHealth provides subsidies to participating small employers to assist in the cost of providing the health insurance for low-income employees and their families. (See Section VII for more information on this program.)

Enrollment in Family Assistance began in August 1998. There were 32,397 individuals participating in the program on June 30, 2005, accounting for 3.8% of the Demonstration population, and representing an 11% increase in caseload from the previous year. Of those enrolled 10,181 were receiving premium assistance to purchase employer-sponsored insurance.

Also, as of June 30, 2005 there were 852 members enrolled in Family Assistance due to their HIV status under the HIV expansion. (See pg. 23 for further discussion on HIV expansion.)

Information on the number of policies purchased and the number of lives covered through Family Assistance Premium Assistance and the Insurance Partnership (IP) is discussed in Section VII.

MassHealth Basic provides benefits to persons who receive state-funded cash assistance through the Emergency Assistance to Elderly, Disabled and Children (EAEDC) program, as well as to Department of Mental Health (DMH) clients who are long-term unemployed and at or below 100% FPL. Basic benefits are provided through managed-care plans for persons who do not have private health insurance. The benefit package does not include non-emergency transportation, adult day health, adult foster care, day habilitation, hospice, personal care services, or private duty nursing. Basic-eligible persons who have private insurance may be eligible for premium assistance. MassHealth does not provide wrap coverage for Basic members who receive premium assistance.

There were 12,861 individuals participating in MassHealth Basic on June 30, 2005, accounting for 2.8% of the Demonstration population, an increase of 19% from the previous year.

MassHealth Essential was implemented on October 1, 2003, restoring coverage to certain long-term unemployed adults who were covered by MassHealth Basic until eligibility changes took place in April 2003. MassHealth Essential covers childless adults, who are long-term unemployed and whose income is at or below 100% FPL. While comprehensive, the benefit package does not include non-emergency transportation, adult day health, adult foster care, day habilitation, hospice, personal care services, or private duty nursing. Members eligible to receive direct coverage of medical benefits must enroll with a MassHealth-contracted PCC before they can receive services. The MassHealth behavioral health contractor provides behavioral health services. Essential-eligible persons who have private insurance may be eligible for premium assistance. MassHealth does not provide wrap coverage for Essential members who receive premium assistance.

MassHealth Essential was introduced on October 1, 2003 with an enrollment cap of 36,000. In January 2005, CMS approved the Commonwealth's request to increase the Essential enrollment cap to a range of 36,000 to 44,000. Applications for benefits by long-term unemployed people have increased considerably over this fiscal year due to the rollout of the EOHHS Virtual Gateway, allowing online application at high volume provider site, and the joint application process for MassHealth and the Uncompensated Care Pool. This fiscal year MassHealth experienced the first implementation of a waiting list for Essential applicants. On June 30, 2005 the snapshot enrollment for Essential was 40, 358 members, with an additional 4000 eligible persons waiting to be enrolled in the program. The Essential caseload, budget, and per member per month costs are reviewed by MassHealth on a bi-weekly basis to enroll the maximum number of people from the waiting list. Persons are enrolled from the waiting list in order of application date as space in the program opens.

MassHealth Limited provides emergency services, including labor and delivery, to unqualified aliens whose immigration status prevents them from being eligible for MassHealth Standard. In SFY 2005, the number of persons receiving MassHealth

Limited increased substantially due to the implementation of the Virtual Gateway and the unification of the applications for MassHealth and the Uncompensated Care Pool (UCP), which requires pre-screening for MassHealth before establishing UCP eligibility. On June 30, 2005, there were a total of 43,442 individuals receiving MassHealth Limited, representing 5% of the Demonstration population. This is an increase of 11,130 individuals since June 30, 2004.

MassHealth Prenatal provides time-limited prenatal services to pregnant women who self-declare gross family income that is at or below 200% of the FPL. This benefit lasts for 60 days, during which time income must be verified in order for MassHealth coverage to continue. Once income is verified, the majority of these women become eligible for MassHealth Standard. There were 446 pregnant women in MassHealth Prenatal on June 30, 2005.

Medical Security Plan (MSP) is available for individuals in Massachusetts who are unemployed, with income up to 400% of FPL, and who are receiving or are eligible to receive unemployment compensation benefits. MSP is offered through the Division of Unemployment Assistance (DUA). The DUA contracts with Blue Cross Blue Shield of Massachusetts to administer the program and provide utilization management services. (See Section VI for more detail).

The following table (Table 1) presents the distribution of MassHealth members by eligibility groups on June 30th for years 1997, 2004, and 2005:

Table 1
Distribution of MassHealth Members by Eligibility Groups on June 30th for years 1997, 2004, and 2005

	30-Jun-97		30-Jun-04		30-Jun-05					
	Eligibility Groups as % of Total MassHealth Reform		**Eligibility Groups as % of Total MassHealth Reform**		**Eligibility Groups as % of Total MassHealth Reform**		**Change from Previous year to SFY05 (from SFY 04 to SFY05)**		**Change From beginning of the Demonstration to SFY05 (from SFY 97 to SFY05)**	
	#	%	#	%	#	%	#	%	#	%
Standard	553,706	99.3%	707,077	86.1%	720,203	83.4%	13,126	1.9%	166,497	30.1%
Basic			10,823	1.3%	11,403	1.3%	580	5.4%	11,403	n/a
Essential			27,261	3.3%	40,358	4.7%	13,097	48.0%	40,358	n/a
CommonHealth	3,666	0.7%	14,335	1.7%	15,567	1.8%	1,232	8.6%	11,901	324.6%
Family Assistance			29,150	3.5%	32,397	3.8%	3,247	11.1%	32,397	n/a
Limited			32,312	3.9%	43,442	5.0%	11,130	34.4%	43,442	n/a
Prenatal			426	0.1%	446	0.1%	20	4.7%	446	n/a
Total MassHealth	557,372	100.0%	821,384	100.0%	863,816	100.0%	42,432	5.2%	306,444	55.0%

Note: These numbers include approximately 6,000 state-only funded, non-qualified alien MassHealth members enrolled in various eligibility groups.

Growth by Age and Geography: The MassHealth Demonstration has had a significant statewide impact (see Table 2). Each Massachusetts County has seen a substantial increase in MassHealth enrollment; with a 37% increase on average for children and a 76% increase on average for adults. The largest percentage growth has occurred in Dukes and Nantucket counties. The smallest growth is seen in Suffolk County.

Table 2
Medicaid Waiver Caseload by County – June 30, 2005

County	*Children #*	*Children % change**	*Adults #*	*Adults % change**	*Total #*	*Total % change**
Barnstable	11,118	37.82%	12,930	89.34%	24,048	61.44%
Berkshire	9,816	48.78%	11,248	90.18%	21,064	68.35%
Bristol	42,013	41.76%	45,867	79.09%	87,880	59.07%
Dukes	819	172.10%	938	204.57%	1,757	188.52%
Essex	54,502	39.28%	53,231	73.29%	107,733	54.23%
Franklin	4,948	44.71%	5,715	88.64%	10,663	65.35%
Hampden	56,855	36.77%	53,477	69.54%	110,332	50.91%
Hampshire	6,505	47.07%	7,938	90.41%	14,443	68.10%
Middlesex	59,041	42.56%	66,699	82.48%	125,740	61.27%
Nantucket	339	235.61%	320	251.59%	659	243.19%
Norfolk	21,036	68.30%	26,138	104.68%	47,174	86.68%
Plymouth	28,230	41.50%	28,573	83.17%	56,803	59.79%
Suffolk	73,553	22.74%	75,160	57.87%	148,713	38.29%
Worcester	51,649	41.42%	53,700	79.57%	105,349	58.60%
Incorrect Zip code	0	n/a	0	n/a	0	n/a
Total	420,424	37.26%	441,934	75.71%	862358	54.60%

*% Change is from implementation of the waiver on July 1, 1997.
** Discrepancies from Table 1 in total MassHealth enrollment are due to difference in date on which data was aggregated.

Update on Operational Activities/ Operational Streamlining: Applicants for MassHealth continued to benefit from a streamlined eligibility process during the eighth year of the Demonstration.

Submission of a Medical Benefit Requests (MBR): MBRs are made available to potential applicants for easy access in a wide variety of locations, such as provider sites including hospitals, health centers, emergency service providers, other state agencies,

and community-based organizations. There are many access points that an individual may use to submit an application for MassHealth benefits.

MassHealth has incorporated the e-MBR technology into the Virtual Gateway Intake, Eligibility and Referral system. The Virtual Gateway builds upon the e-MBR technology by allowing contracted hospitals and community health center to apply for MassHealth programs online via a secured EOHHS internet portal. MassHealth piloted the e-MBR in a collaborative effort with Massachusetts General Hospital. Connectivity was successful in transmitting application information electronically from the remote site to the MassHealth Central Processing Unit (CPU). As of July 2005, there are 120 MassHealth Virtual Gateway providers that have access to submit electronic applications via the Virtual Gateway, of which 72 are hospital sites and 48 are community health centers.

On October 1, 2004, MassHealth added eligibility for three new programs to the MA21 eligibility system's decision tree logic. These three programs account for seven new categories of assistance supported by MA21 (the MassHealth eligibility determination system). While these programs are not part of the MassHealth Demonstration, this consolidation of the determination function among Masshealth and other health programs for low-income people insures that all applicants receive the richest benefit available to them.

Children's Medical Security Plan and Healthy Start: Four new categories were added to MA21 to determine eligibility for the state-funded Children's Medical Security Plan (CMSP) and one new category was assigned for the SCHIP-funded Healthy Start Program (HSP).

Uncompensated Care Pool (UCP): On October 1, 2004, MassHealth added two new unique categories in MA21 to determine eligibility for the state's Uncompensated Care Pool (UCP). MassHealth added new decision tree logic that automatically determines UCP eligibility for denied MassHealth members who meet the state's eligibility guidelines for the UCP program. This new eligibility process ensures that all MassHealth applicants are first screened and determined ineligible for MassHealth before approving services for the state's UCP program.

MassHealth Enrollment Centers (MECs): MECs are located in Revere, Tewksbury, Taunton, and Springfield. There is a single toll free 888 number that receives all incoming calls and automatically refers the caller to the MEC closest to the caller's location. MEC staff members are available to provide telephone assistance to individuals preparing an MBR for submission. MECs also receive MBRs, which may be submitted by mail, fax, or hand-delivered to one of the MEC locations. MECs that are co-located with other EOHHS agencies have worked to share information, resulting in more reliable and efficient service to their customers.

Out-Stationed Eligibility Worker: MassHealth has an out-stationed eligibility worker at Boston Medical Center, the Commonwealth's highest volume provider for low-income residents, to assist MassHealth members with access to the application process.

Virtual Gateway Deployment Coordinators: To support the release of the Virtual Gateway E-MBR application, MassHealth has allocated four Virtual Gateway Deployment coordinator positions to the Central Processing Unit (CPU) to assist new VG providers with technical questions and on-site support. This new role has helped to reduce the number of inquiries and electronic application issues that the CPU received during the pilot implementation.

Mail In: in SFY05 applicants mailed approximately 72% of MBRs directly to the CPU. The remaining 28% of the MBRs received at the CPU were received electronically via the Virtual Gateway and its associated EOHHS business partners.

Training Resources: The training unit is involved in training MassHealth Operations (MHO) staff on the new initiatives involving CMSP, Healthy Start and Uncompensated Care. In the last quarter of SFY05, the training unit began training MEC staff on the Community Elders Integration to the MA21 environment. The MECs responded to a deficit of eligibility workers by creating mixed function units. These units allowed the MEC offices to have workers respond to a variety of eligibility and customer service issues for all MassHealth populations.

Processing MBRs: All applications received for non-institutionalized individuals under age 65 continue to be processed at the CPU. Each MBR is entered into the MA21 automated eligibility system, which determines whether or not the individual is eligible for MassHealth benefits, or if additional information is needed.

The CPU received approximately 775 MBRs per day in SFY05; this number includes 557 paper MBRs and 218 Electronic MBRs, averaging 15,526 MBRs per month. In comparison, there was an average of 9,600 MBRs filed per month in SFY04.

Average turnaround time for MBRs was 14.5 days over the course of SFY05 as compared to 11.8 in SFY03. Processing turnaround time increased in SFY05 as a result of joint application for MassHealth and the Uncompensated Care Pool. SFY05 was the first year that UCP members were required to apply via the MassHealth application to access services available through the Uncompensated Care Pool. This combined application process significantly increased the number of applications that MassHealth processed in SFY05.

All MBRs are processed immediately at the CPU. 65% are received with all necessary verification information attached, while 35% require a request for additional information or verifications. Virtual Gateway providers indicate on their electronic applications if they will be forwarding verifications to the CPU. When indicated on the electronic application, Virtual Gateway providers are given three days to fax follow-up verifications required to process electronic applications. This allows most VG applications to be processed within three days without MEC follow-up for verifications. Verifications attached to paper MBRs are reviewed by eligibility staff and prepared for data entry. A simplified

application form was introduced in 1997 and has been revised several times, most recently in September of 2005.

Improvements in the system for receiving and processing applications reflect the fact that Massachusetts has: (1) worked hard to develop a mail-in and electronic application process as part of its expansion efforts, (2) increased the efficiency with which applications can be processed, (3) standardized the outcome of eligibility determination decisions, (4) worked to develop verification and matching processes with SSA and DOR, and (5) developed unattended E-MBR/VGW technologies.

One important factor that has facilitated these improvements is the refocusing of the eligibility worker's responsibilities from after-receipt processing to working with the individual in the preparation of an MBR, and clarifying and assuring the completeness of information that is sent to MassHealth. When received, the information is entered on MA21 and the system renders an eligibility decision. Consequently, eligibility workers have more time available to focus their efforts on answering questions and assisting applicants with the completion of an MBR.

In SFY05, MassHealth processed a total of 186,311 applications (including new, re-application, and maintenance applications), 128,811 of which were new MBRs. Of these new MBRs, 94% were processed and 6% were pending on June 30, 2005.

In October 2003, MassHealth assumed responsibility for administering and processing applications for the Healthy Start Program, formerly administered by the Massachusetts Department of Public Health. The Healthy Start Program provides ambulatory prenatal and preventive care services to pregnant women who are eligible for MassHealth Limited, which does not pay for these services. Healthy Start is an SCHIP program for unborn children. In addition to Healthy Start, MassHealth also assumed sole responsibility for the Children's Medical Security Program, formerly a DPH program. Decision tree logic was added to the MA21 system to perform eligibility determinations for these additional programs.

Quality Control: Under the Demonstration, MassHealth uses an alternative Medicaid Eligibility Quality Control (MEQC) review process, comprised of a series of evaluations and informational studies related to MassHealth eligibility polices, procedures, and processes.

Two studies, the Validation of MassHealth's Classification of Expansion and Non-Expansion Eligibles (MA21 System Validation) Study and the Insurance Partnership Subsidy Study, occur annually. The first study verifies that the data in the system is consistent with information provided by the member, the integrity of the eligibility decision tree (in MA21), and the benefits assigned to the member. The second study assesses whether members were correctly determined eligible for a subsidy of employer-sponsored health insurance. Additionally, every six months MEQC conducts alternative studies on various aspects of eligibility for (1) MassHealth's "traditional"

Medicaid population including those members over age 65 who are in need of long-term-care services and (2) MassHealth's Health Care Reform population – including those members under age 65 and non–institutionalized.

In SFY05, MassHealth conducted two alternative studies, as well as one additional study, the Payment Accuracy and Measurement (PAM) study, which are described below:

Study 1 – FY05 Citizenship and Immigration Study:

The goal of this study was to evaluate MassHealth compliance with regulations that stipulate that citizens and qualified aliens may receive MassHealth under any coverage type if they meet the eligibility requirements. Aliens with unqualifying status may not receive MassHealth Standard; however, they may be eligible for MassHealth Limited.

In order to assess compliance with MassHealth immigration policy, this study reviewed non-institutionalized citizens and aliens under age 65 applying for or receiving MassHealth benefits who stated they were Citizens, Qualified Aliens, Protected Aliens or Aliens With Special Status (AWSS). Aliens who fail upon request to submit verification of their immigration status within 60 days will subsequently be eligible only for MassHealth Limited, or ineligible for any MassHealth coverage. The sample consisted of 210 cases, which represented 224 members who had declared their immigration status as citizens, qualified aliens, protected aliens, or AWSS. The sample was randomly selected from systemic reports that were coded on the MA21 citizenship screen as C (citizen), M (meets), B (barred), P (PRUCOL), and N (no status).

Study findings included recommendations regarding:

- Enhanced education and training regarding MassHealth alien and citizenship policy, both internally and externally.
- MA21 system monitoring and enhancements to ensure that members are appropriately determined as being eligible for MassHealth.
- INS matching.

Study 2 – FY05 MassHealth Eligibility Review (MER) Transition Profiling Process Study:

The goal of this study was to evaluate the effectiveness of the MassHealth Eligibility Review (MER) Transition Profiling Process, which automatically sends eligibility review forms to members turning age 65. This study evaluated the continuity of member eligibility during the transitioning from MA21 (the eligibility determination system for members under age 65 subject to the 1115 MassHealth waiver) to PACES (the eligibility determination system for members aged 65 and over). MassHealth members aged 65 and older are required to meet various income and asset rules that do not apply to non-institutionalized MassHealth members under age 65 (those eligible through the Demonstration). When a Demonstration-eligible member reaches age 65, with certain exclusions, the member becomes subject to the "Traditional" income and asset rules contained in 130 CMR 515.000 through 522.000 (Volume II). Members are selected for

eligibility review based upon the category of assistance for which they are eligible, and their age, which must be equal to or greater than 64 years and 11 months. In total, the sample consisted of 210 members aged 64 and 10 months who received the MER review form. The sample selection was derived from a systems generated report of members who received the MER review form.

To date, pilot study findings show that the process is an effective transitioning mechanism for this population.

FY05 Payment, Accuracy and Measurement (PAM) Study:

The goal of this study was to assess whether members were eligible for MassHealth during the requested service date for payment. This study reviewed eligibility at time of payment. The sample size consisted of 100 cases: 50 managed care cases and 50 fee-for-service.

The study involved a review of data from the PACES eligibility system (for non-Demonstration eligibles), the MA21 eligibility system (for Demonstration-eligibles), and the MMIS claims system for the 100 sample members including a review and examination of the date of service and analysis of the case record. For Demonstration-eligibles, an MA-21 decision tree was completed to map the eligibility process from beginning to final determination. For non-Demonstration eligibles, a manual calculation was completed. Expected results were compared to the actual disposition, including: the type of disposition; eligibility during the dates of service; the eligible category during the dates of service; eligible category during the last redetermination; types of errors during the redetermination process (income, assets, citizenship, TPL, health insurance, other); whether the error affected eligibility; and whether the disposition was wrong because of the eligibility error.

Study findings indicated one member in the sample was terminated prior to the date of service and reopened after the date of service, which constituted a 1% rate of error.

Re-determination: MassHealth continues to monitor the rate of re-determinations to ensure that all households are re-determined annually.

In SFY05, MassHealth performed annual eligibility re-determinations of approximately 207,115 households representing approximately 517,718 members. MassHealth also performed targeted re-determinations based on income or new hire information it received from the Department of Revenue (DOR). MassHealth uses DOR matches to identify discrepancies between the income and employment status reported by its members and DOR records. It follows up on match information with "targeted reviews" of member eligibility. Members are informed of the match information that was reported and given an opportunity to respond and verify their information accordingly. MassHealth performed 30,811 determinations in SFY05 based on DOR match information.

MassHealth also maintained its disability review process, Continuing Disability Review (CDR), in SFY05. The CDR process ensures that MassHealth members who were approved on the basis of a disability continue to meet the disability criteria as outlined in MassHealth regulations. In SFY05 MassHealth targeted 10,580 CDR reviews.

MassHealth Member Booklet (HCR-2) Updates: The member booklet is updated quarterly, whenever a change is made in eligibility rules or income standards. Some of the major revisions of note this year, SFY2005, were the following.

- A new design, effective July 2005, which incorporated all parts of the MassHealth Demonstration application package into one "booklet". This new design enhanced ease of use and cost-effectiveness.
- In January 2005, the Children's Medical Security Plan (CMSP) and Healthy Start were added to the booklet as MassHealth programs. Also, information about the Uncompensated Care Pool was added to the booklet.

(See Attachment 1 in Appendix B for the updated MassHealth Member booklet)

Special efforts to enroll persons with HIV: As of the end of SFY05, there were 852 persons enrolled in MassHealth Family Assistance due to the HIV expansion through the waiver. The goal of the HIV expansion is to provide health care coverage to eligible individuals who are HIV positive, promoting access to early treatment of HIV disease, and reducing or delaying the progression of AIDS.

In SFY05, MassHealth and the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School reported the results of two evaluation efforts: the HIV Expansion Member Satisfaction Survey and the Baseline Health Services Utilization Study.

The results of the survey indicate that the HIV Expansion did increase access to primary, specialty, and behavioral health care for the survey respondents upon their enrollment in the HIV Expansion program. Furthermore, the HIV Expansion members who responded to the survey were generally very satisfied with the care they were receiving and with their interactions with providers and the staff at their providers' offices. The survey results also indicate that there were differences among survey respondent sub-groups, as defined by gender, race/ethnicity, and educational level.

The Baseline Health Services Utilization study documents those health care services which were paid by MassHealth and provided to the HIV Expansion members during calendar year 2002. The report details the HIV Expansion members' characteristics, hospital and emergency department utilization, office visits, receipt of medical screenings and procedures, receipt of anti-retroviral drug therapy, behavioral health services utilization, and pharmaceutical expenditures.

Current Activities: The data in this report will be updated with data for subsequent calendar years so that improvements in or problems with the provision of health services to HIV Expansion members can be identified.

IV. Member Outreach, Marketing and Education:

The MassHealth Operations Member Services Unit provides a variety of member services including the operation of a high volume toll-free customer service telephone line. The Customer Service Center received a total of 1,084,290 calls in SFY05.

MassHealth Operations Member Services Unit supports the philosophy that MassHealth's primary customer is the MassHealth member.

Other Member Services Unit responsibilities include:

- Targeted outreach
- Member education
- Applicant assistance
- Management of the Medical Benefits Request (MBR) application process
- Determination of eligibility and review of continued eligibility
- Selection of and enrollment into a health plan
- Communication with members
- Development of enrollment materials in conjunction with the Enrollment Broker
- Quality assurance

The Targeted Outreach/Member Education group within the Member Services Unit is primarily responsible for identifying underserved communities and populations as well as developing targeted efforts to provide education about the availability of MassHealth benefits.

Targeted Marketing Strategies:

Outreach to Homeless Individuals: During SFY05, MassHealth partnered with two large Boston shelters, St. Francis House and Pine Street Inn, to pilot electronic applications. This initiative allowed real-time eligibility decisions for electronic applications filed for this population. MassHealth continues to ensure that homeless individuals maintain their access to health care by providing a homeless indicator at the point of entry. By providing a "homeless" check-off box on the MBR, the individual, advocate or service provider is ensured that the case is not closed because of the lack of a permanent address.

Expedited Eligibility Pilot for Disabled Homeless Individuals: Advocates working in the homeless community raised concern about MassHealth's standard notification procedure and its impact on homeless individuals. They also expressed concern about the average length of time needed for the disability review process (approximately 60 days) and its impact on homeless individuals and their service providers. In response, this pilot was developed and implemented at a high volume homeless health access

point to provide a 72 hour expedited eligibility process to determine disability in order to meet the needs of this transient population. During SFY05, 187 expedited disability applications for homeless individuals were processed and 94 disability determinations were approved.

Partnering with Our Schools: MassHealth's school-based outreach activities for children and families continued in collaboration with *Covering Kids and Families (CKF):* Massachusetts. CKF is a Robert Wood Johnson Foundation "Covering Kids" organization. In SFY05, MassHealth maintained its commitment to work closely on this effort with its state sponsor, *Health Care for All*; a Boston-based health care advocacy organization. Active collaboration exists between both organizations with shared data and information.

Department of Corrections Project (DOC): Effective November 2004, MassHealth implemented a process with DOC to enroll those inmates who are eligible to receive MassHealth benefits upon re-entry into the community.

To date:

Applications initiated:	1157
MassHealth cards received:	689
Applications pending (denied/other/in process):	332
Essential Program wait list:	136

MassHealth Behavioral Task Force: This task force was formed in January of 2005 to ensure the success of community re-entry for criminal offenders with physical or behavioral health disorders. The state agencies involved with this task force include DMH, DOC, DPH, Parole Board, MBHP and MassHealth. The task force developed the Health Care Access Protocol Form (HAP), which is currently in use at community re-entry centers.

Linking Food and Health: This work group was formed to target and outreach MassHealth members eligible for the Food Stamp Program. The agencies involved with this project include the Boston Public Health Commission (BPHC), the Boston Nutrition Access Project (BNAP), the Department of Transitional Assistance (DTA), Health Care For All (HCFA), and the WIC Program.

In-Service Presentations: The Member Education Unit conducts scheduled yearly in-service presentations with the Massachusetts Office of Refugees and Immigrants-Refugee Resettlement Training Unit, advocates for the homeless, shelters and other facilities working with this population, and the Massachusetts Department of Veteran's Services. These presentations provide education regarding MassHealth benefits, the application process, and post-enrollment activities.

Promotional Materials and Literature: Certain Member Education and outreach materials have been translated into the following languages: Spanish, Portuguese,

Chinese, Vietnamese, Haitian Creole, Russian, Cambodian, and Laotian. These are the languages predominately spoken by MassHealth members, as indicated by MA21 data.

Area Health Education Centers Regional Meetings: To support Member Education efforts, MassHealth continued to provide funding for the Health Access Networks (HANs). The six regional HANs were developed in partnership with the University of Massachusetts Medical School's Area Health Education Center (AHEC) as a forum to share information, strategies, and experiences on effective member education practices. MassHealth Operations continued to fund this effort in FY05 as the MassHealth Technical Forums. The meetings currently promote information dissemination, sharing of best practices, and building of community/public sector linkages to increase targeted outreach and member education about MassHealth.

Customer Service: Below are the key areas of MassHealth customer service activity.

Individuals interested in finding out about MassHealth are directed to the MassHealth Customer Service Center's toll-free 800-telephone number. This phone number is operated by MAXIMUS, a contracted vendor that provides customer service to all MassHealth members or potential members. As an enrollment broker, MAXIMUS is responsible for educating members and providing neutral, third-party counseling about the various MassHealth plan options. MAXIMUS is also contracted to coordinate non-emergency, medically necessary transportation for MassHealth members.

The Customer Service Center answers calls from 8AM to 5PM, Monday through Friday, including TTY service for the hearing impaired. Over 51% of the Customer Service Center staff speaks another language in addition to English. Additionally, AT&T interpreting services are available in instances when other language capacity is needed. At peak times the number of calls received at the Customer Service Center has been more than 6,700 per day. During the past year the average monthly call volume decreased 13% from 103,553 in SFY04 to 90,358 in SFY05.

Health Benefit Advisors at the Customer Service Center are trained to respond to inquiries about MassHealth, send out applications to those who are interested in applying, and assist members in enrolling in health plans that best meet their needs. Also, there are two community representatives who are assigned to the BMC HealthNet and Network Health MCOs.

Eligibility Maintenance: Eligibility staff at the MassHealth Enrollment Centers (MECs) located in Revere, Springfield, Taunton, and Tewksbury, respond to case-specific eligibility questions from MassHealth members and conduct related case maintenance duties on cases filed for determination and profiling as necessary. MEC caseloads increased by 30%, including related customer service calls, in SFY05. In addition, as part of the Virtual Gateway deployment, each MEC oversaw the implementation of electronic applications for members known to the system, processing cases within a six-

day turnaround. The MEC staff received over 1,100,000 calls in SFY05, and more than 900,000 calls were customer calls related to Demonstration-eligible individuals.

Training: MassHealth and MAXIMUS staff receive ongoing training about eligibility changes, new benefit programs, and implementation of all MassHealth expansions, including electronic application processing for the under 65 population. Training enables staff to appropriately respond to customer issues and make appropriate referrals. In addition, all staff receive detailed operational memoranda that describe policies and procedures related to expansions prior to implementation.

The MassHealth Operations Training Unit consists of a Director and four training liaisons and is responsible for all training sessions at the four MECs and the CPU. They ensure eligibility workers receive training in existing and new eligibility policy as well as related systems and customer service areas. MassHealth utilizes an extensive six week training program for both new MassHealth eligibility workers and those who assumed Health Care Reform eligibility duties after having worked in a different area of MassHealth. The training covers the basics of health care reform policy, detailed explanations of coverage (including the Insurance Partnership program), understanding a member's citizenship, and the basics of all eligibility-related computer systems, including MA21, MMIS, and the Recipient Eligibility Verification System (REVS). MassHealth also offers refresher courses, job aids and other learning tools on these computer systems and applicable regulations and policies, as well as areas in which workers request additional training or mentoring. In SFY05, MassHealth targeted training sessions on:

1) MA21 Integration
2) Uncompensated Care
3) Deductibles
4) Privacy
5) Matching

Quality Improvement Projects: MassHealth continued to remain committed to assessing and improving the health care services received by its members in SFY05. Each MassHealth Enrollment Center (MEC) and the Central Processing Unit (CPU) continued to assess and develop quality improvement projects in a variety of topic areas which included:

Revere MassHealth Enrollment Center:

- Limited Call Distribution Analysis
- Validation of Private Health Insurance Premium Payment for Long-Term Care Cases
- Second Level Review (Team manager reviews application for accuracy completed by staff member)
- DOR Match Processing
- Monitoring Long-Term Care Cases (for non-covered medical service and guardian expenses incurred by members)

Springfield MassHealth Enrollment Center:

- Medex Cost Savings
- Home Maintenance Allowance
- Insurance Partnership Coordination
- Recipient Identification (RID) Case Resolution
- Third Party Liaison for all Premium Assistance Categories
- REVS/EDS Problem Resolution

Taunton MassHealth Enrollment Center:

- Senior Care Options (SCO) enrollment for all MECs and tracking
- Developing and integrating the Community Integration Team (CIT) into the Virtual Gateway workflow
- Developing and supporting the involvement of the Long Term Care Intake unit into the MA21 environment
- Workflow and statistical tracking for all aspects of the Virtual Gateway involvement with operational functions

Tewksbury MassHealth Enrollment Center:

- Development and implementation of a new Health Care Reform mail prioritization system that is based on timeliness of case closing and quality of case action versus date of assignment
- Long-term care research project identifying high cost loopholes and perceived barriers to cost-effective processing of nursing home cases
- Transitioning of all free-standing databases to an internet-based Mail Management System developed by the Central Office

Central Processing Unit:

- Disability Supplement Daily Review
- Disability Supplement Tracking and Routing
- Virtual Gateway Implementation
- In-depth study and analysis of applications submitted via the Virtual Gateway by providers

Cultural Competency: MassHealth continued to provide materials to applicants and members in SFY05. Specific materials and publications were made available in the following eight languages, in addition to English: Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian, Spanish, and Vietnamese. These materials include MassHealth Member Eligibility Booklets and informational brochures.

Cultural Competency in Adapting Materials for Latino Spanish-speaking members: A committee comprised of representatives of the MCOs and PCCs continues to work cooperatively towards the development of materials targeted to Spanish speaking members as part of the quality improvement project process. Booklets, television public service announcements, and a tool kit are scheduled to be the results of this process.

MassHealth Staff Training Activities: MassHealth provides ongoing information, awareness, and skill building opportunities to agency staff on diversity and cultural competency. Human Resources conduct ongoing diversity and cultural competency activities, including workshops, cultural diversity luncheons, guest speakers, etc.

V. Enrollment in Health Plans

Once MassHealth Operations establishes an individual's eligibility for MassHealth, Health Benefit Advisors (HBAs) at the MassHealth Customer Service Center assist the member in selecting a health plan based on the geographic location of their residence and their health care needs.

Enrollment in a health plan increased by approximately 4.7% in the eighth year of the Demonstration, from 582,664 at the beginning of SFY05 to 610,437 at the end of SFY05. 89% of those participating in the MassHealth Demonstration receive health benefits from enrollment in a health plan, while the other 11% have active third-party insurance, a 10% decrease from FY03. The health plan options include either the Primary Care Clinician (PCC) Plan or a capitated managed care organization (MCO). On June 30, 2005 approximately 276,295 MassHealth members were enrolled in the PCC Plan and 334,142 were enrolled in the capitated MCOs, with additional enrollees in the process of selecting or being assigned to a health plan.

During SFY05, Standard, Family Assistance, and Basic coverage types had an increase of 55,714 enrollments into the MCO Program. Most of this increase occurred because doctors who had members enrolled with them through the PCC Plan were allowed to convert their members to the MCO with which the doctor is affiliated. Prior to conversion, members were notified and could choose to remain with their doctor through the PCC Plan instead.

Standard Enrollment: As of June 30, 2005, 536,252 MassHealth Demonstration members eligible for Standard coverage were enrolled in managed care. Of those members, 59.14% were enrolled in an MCO and 40.86% were enrolled in the PCC Plan.

Family Assistance Enrollment: There were 22,849 MassHealth Demonstration members eligible for Family Assistance coverage enrolled in managed care as of June 30, 2005. Of those members, 46.85% were enrolled in an MCO and 53.15% were enrolled in the PCC Plan.

Basic Enrollment: Members eligible for Basic benefits must be enrolled in an MCO or in the PCC Plan in order to receive services. As of June 30, 2005 there were 12,499 Basic members. Of those members, 50.59% were enrolled in an MCO and 49.41% were enrolled in the PCC Plan.

Essential Enrollment: As of June 30, 2005 there were 38,837 MassHealth Essential members enrolled in the PCC Plan. Essential members cannot choose an MCO.

The following table (Table 3) presents a summary of the distribution of MassHealth Demonstration members in an MCO or the PCC Plan, by coverage type:

Table 3
Distribution of MassHealth Demonstration Members in Managed Care Plans
By Coverage Type SFY04 and SFY05 Comparison

Managed Care Plan	Standard #	Standard %	Family Assistance #	Family Assistance %	Basic #	Basic %	Essential #	Essential %	SFY04 Plan Total #	SFY04 Plan Total %
MCO Plan	266,639	50%	8,121	53%	3,668	37%	n/a	n/a	278,428	48%
PCC Plan	266,451	50%	7,153	47%	6,154	63%	24,478	100%	304,236	52%
Managed Care Plan	**Standard #**	**Standard %**	**Family Assistance #**	**Family Assistance %**	**Basic #**	**Basic %**	**Essential #**	**Essential %**	**SFY05 Plan Total #**	**SFY05 Plan Total %**
MCO Plan	317,114	59%	10,705	47%	6,323	51%	n/a	n/a	334,142	55%
PCC Plan	219,138	41%	12,144	53%	6,176	49%	38,837	100%	276,295	45%

VI. Service Delivery

Behavioral Health Program and PCC Network Management Integration: In SFY02, MassHealth procured a combination PCC network management services and BHP full service contract. This contract continued in SFY05, and key goals included: increased integration of behavioral health and medical services, improved children's behavioral health services, services for special populations, and a focus on rehabilitation and recovery from mental illness and addiction. During SFY05, MassHealth and the contractor worked together to implement and continue new and existing integration activities. These integration efforts include, but are not limited to:

- Continued provision of two additional levels of care management support for behavioral health (BH) providers and PCCs. These levels include care coordination and targeted outreach, and they are available to support the delivery of care to selected members by PCCs and BH providers;
- Implementation of several conferences designed to help PCCs and BH providers better integrate medical and BH care for members;
- Continued distribution of member and provider newsletters that address issues related to both medical and BH care. These provider newsletters go to both PCCs and BH Providers (See pages 39 for a list of topics included in these newsletters in SFY05).
- Refinement of a BH related measure included in the PCC Profile Report. This measure is described more fully in the PCC Profile Report section.

  Next Steps: New PCC Plan integration materials were in development in SFY05. These new materials include a fact sheet on depression and diabetes, and a series of fact sheets on treating depression in primary care settings. These materials will be finalized in SFY06, and will be made available to members and providers through the PCC Plan Health Education Materials Catalog. Integration materials developed in previous contract years and described in previous waiver reports continue to be made available to members and providers.

In SFY05, the PCC Plan continued to endorse the following materials and promoted their use by making them available through the PCC Plan Health Education Materials Catalog:

- The Patient Health Questionnaire (PHQ-9) Depression Screening Tool Questionnaire by Pfizer;
- The Pediatric Symptom Checklist and the Pediatric Symptom Checklist Youth (PSC-Y) Report and Scoring Instructions by Michael Jellinek, MD, and J. Michael Murphy, Ed.D., Massachusetts General Hospital;
- A fact sheet for members, *What Is Depression*, developed by Robert Wood Johnson Foundation; and
- Providing Care to Members with Serious Mental Illness.

The contract also contained a performance incentive for SFY05 that addressed issues of BH and medical care integration. Specifically, that performance incentive was the Pediatric Psychiatric Consultative Service Development Performance Incentive, also known as the Massachusetts Child Psychiatric Access Project (MCPAP). MCPAP has supported the development of regional teams of child psychiatrists, social workers or psychologists, and care coordinators that are available to consult with primary care providers who are seeing children with behavioral health issues in their primary care practices.

During SFY05, MBHP facilitated a set of focus groups between PCCs and Behavioral Health Providers (BHPs) to assess the frequency and quality of interactions between BHPs and PCCs. The goal of the groups was to identify barriers to communication and to identify suggestions for activities that MBHP could undertake to improve communication between these types of providers, which could then lead to improved coordination of care for members receiving care from PCCs and BHPs, within the confines of applicable state and federal laws regarding confidentiality. MBHP is currently pulling together the results of the focus groups, and will be providing MassHealth with recommendations for improving communication between PCCs and BHPs in SFY06.

> *Next Steps*: During SFY06, MBHP will continue to focus on improving integration between BH and PCC providers. One particular initiative that will begin in this SFY is the provision of an Individual Care Plan (ICP) Report to PCCs. The ICP Report will be sent to the PCC with which each member receiving Intensive Clinical Management (ICM) services through MBHP is enrolled, and will provide the PCC with information on the services that ICM enrolled members are receiving. Thus, the PCC will be fully informed of the plan of care for their members, and will be able to integrate the PCC's services into that plan.

Behavioral Health Program: Working closely with consumers, family members, providers, state agencies, and other stakeholders continued to be a priority for the Behavioral Health Program in SFY05. The following is a summary of some highlights from those activities.

Developing a Unified Behavioral Health System: In 2003, the Commissioner of the Department of Mental Health (DMH), in her capacity as head of the State Mental Health Authority, was directed by the Secretary of Health and Human Services to develop a proposal for a unified behavioral health system. This was a direct outgrowth of the reorganization of the Executive Office of Health and Human Services, one component of which was the transferring of oversight of the MassHealth Behavioral Health program to DMH.

This project, formally launched in late 2004, was designed to develop an approach to coordinating the design, management, and delivery of publicly-funded behavioral health services across EOHHS agencies, specifically focusing on MassHealth and DMH, within

the broader context of the 1115 Waiver, other MassHealth and DMH programmatic initiatives, and Safety Net Care.

This project is being led by a multidisciplinary steering group representing multiple specialties and staff levels from various agencies within EOHHS, in addition to DMH and MassHealth.

Current project activities focus on conducting a thorough analysis of the current state of existing systems across numerous dimensions, including expenditures, utilization, purchasing and contracting, reimbursement practices, and delivery systems. Additionally, the project will include an analysis of best practices with respect to service delivery, program strategies, and financial and administrative structures.

Future activities will be determined based on the outcome of these efforts.

Conference for Consumers on Rehabilitation and Recovery: In SFY05, MBHP again hosted a statewide conference for consumers on rehabilitation and recovery from mental illness and addictions. The conference was attended by several hundred individuals including consumers, advocacy representatives, providers, and BH program staff, which was the largest attendance to date.

System of Care Initiatives: MassHealth, in partnership with CMS and the state's Departments of Education (DOE), Mental Health (DMH), and Social Services (DSS), sponsors two pilot programs to coordinate behavioral health and social services for MassHealth managed care-eligible children aged three through eighteen who have serious emotional disturbance (SED).

Neighborhood Health Plan, Inc. (NHP) operates the Mental Health Services Program for Youth (MHSPY) pilot within its larger MCO contract with MassHealth. The program operated exclusively in the cities of Cambridge and Somerville from its inception in 1998 until the last quarter of SFY02, when it was expanded to include the cities of Everett, Malden, and Medford. The program formerly served up to 30 children at a time, and now serves up to 80 children. During SFY05, MHSPY had an average monthly enrollment of approximately 66 children. By the end of SFY05, MHSPY had served 199 children since its inception. Children in MHSPY continue to show functional improvement, according to widely used measures, while spending 89% of their time in the program living at home, away from acute and long-term care settings.

The second pilot, Coordinated Family Focused Care (CFFC), is managed by MassHealth's behavioral health "carve out" - the Massachusetts Behavioral Health Partnership (MBHP). MBHP contracts with five of its network providers to serve up to 250 children at a time across five geographical service sites (Brockton, New Bedford, Lawrence, Springfield and Worcester). Since it began enrollment in June 2003, CFFC has enrolled a total of 570 members.

The service models for CFFC and MHSPY have some programmatic similarities, and some significant differences. Both pilots integrate behavioral health care with supportive services in the home, school, and community. This includes: mentoring, recreation and skill development opportunities, collaborative care planning, care coordination, and care management. The differences in the models are found within the coordination of health care. The MHSPY model integrates all physical health care and behavioral health care, while the CFFC model coordinates health care with a primary care provider though the MassHealth Primary Care Clinician (PCC) Plan.

The CFFC evaluation is supported by grant funds from the Center for Health Care Strategies (CHCS) in Lawrenceville, NJ, and is being carried out by the Center for Mental Health Services Research at the University of Massachusetts Medical School. Analysis of clinical outcome data shows significant functional improvement in the home, school and community environments as measured by the Child & Adolescent Functional Assessment Scale (CAFAS). Initial CAFAS scores average 145, demonstrating serious impairment and risk of residential placement. After six months in the program, follow-up CAFAS scores average 105, demonstrating significant improvement and increased ability to respond to community-based treatment services. Additional findings following 12 months of enrollment are forthcoming and will inform if CFFC enrollees maintain these improvements. Analysis of cost data is less robust, with no change in inpatient costs and utilization found for enrollees from pre to post discharge, and with 15% of children accessing inpatient care prior to and after CFFC enrollment. Slight changes in cost and utilization are seen in diversionary levels of care but are not statistically significant. Additional analyses on a larger sample of enrollees, comparisons of children who graduate versus withdraw from the program, and utilization of other state funded supports (residential care) is forthcoming.

Depression and Primary Care: MassHealth, in collaboration with three of its contracted managed care organizations and the University of Massachusetts Medical School's Department of Family Medicine and Community Health, received a Robert Wood Johnson Grant on Improving Treatment of Depression in Primary Care. The two-year implementation grant began in April 2003 and ended in March 2005; however, with additional funding provided by MassHealth through the Massachusetts Behavioral Health Partnership, the project was continued through June 2005.

The project supports development and testing of a model for care management for MassHealth members with chronic depression by providing care management support and primary care provider training to identify and treat depression in the primary care setting as appropriate. The care manager offers general support, patient education, self-management tips, assistance with medication compliance, and assistance in arranging behavioral health therapy. The model will be tested using one care manager for a community health center and another care manager for a group of smaller sites, including a few group practice sites and an outpatient department site.

Over the life of the project, hundreds of members have been screened and those who meet the criteria have been enrolled in the program. Preliminary data show that many of the members who enrolled in care management showed an improvement in their depression and compliance with their treatment regimens. These promising early results will allow replication of some of the basic components of the project, such as the use of educational materials. An evaluation is underway to analyze the effect of the program and if there is an impact on the use and cost of services.

PCC Capacity Report: MassHealth's provider capacity assessment continues to show that there is sufficient access statewide for members who choose PCCs. The PCC Plan issues a capacity report every six months to identify potential access issues for PCC Plan members. This report provides a snapshot of MassHealth enrollment and contains information on the PCC Plan and unenrolled populations by service area. As of July 1, 2005, there were a total of 1,117 PCCs and 1,989 PCC sites, of which 1,628 were open sites. At that time there were a total of 1,499,423 slots, with 247,419 PCC Plan enrollees occupying slots, leaving a total of 1,225,004 slots available.

Performance Improvement Services (PIMS): In SFY05, the PIMS vendor, MBHP, continued to assist the PCC Plan in managing its network of PCCs, and in working with PCCs on quality improvement efforts. Under a single contract, MBHP manages both the PIMS process and the behavioral health program for the PCC Plan. During SFY05, the Partnership was responsible for distributing PCC Profile Reports and other related reports that are central to the PCC Plan's quality improvement activities, and for collaborating with PCCs in quality improvement (QI) activities. The PCC Profile Report and the related activities are discussed in detail in Section VIII.

MBHP, through the PIMS program, continues to maintain responsibility for managing the PCC Plan telephone hotline, which is focused on answering PCC questions. PCC Plan members with customer service concerns direct their calls to the MassHealth Customer Service Center. That call center is operated under a separate contract between MassHealth and MAXIMUS.

Quality Forums: Through the PIMS, MBHP conducts a series of statewide quality forums for PCCs and their staff. Forum topics are based on the needs of the PCCs as expressed to the Regional Network Managers (RNMs). The SFY05 quality forum topics, dates, and location were as follows:

October 20, 2004: Improving Your Prescribing Patterns Using the MassHealth Pharmacy Program (Worcester)

November 10, 2004: Effective Management of Depression in a Primary Care Setting (Boston)

November 17, 2004: Effective Management of Depression in a Primary Care Setting (Hyannis)

June 8, 2005: Improving the Management of Substance Abuse in the PCC Office (Brockton)

May 25, 2005: Effective Management of Depression in a Primary Care Setting (West Springfield)

> *Next Steps:* In SFY06, MBHP, through the PIMS program, will continue to hold quality forums for both PCCs and behavioral health providers.

Provider Education Activity: The PCC Plan continued to pursue a vigorous provider education agenda, focusing on a broad range of the PCC Plan's components.

PCC Plan Quarterly: The *PCC Plan Quarterly* is a publication providing information to the PCC Plan's providers, and behavioral health providers. This publication opens with a letter from the Medical Director, the PCC Plan Director, or the MassHealth BH Programs Deputy Commissioner that addresses a particular topic and how it relates to MassHealth and the providers. The following is a sampling of topics included in the *PCC Plan Quarterly* in SFY05.

Summer 04

- Cape Cod PCC Transforming Systems
- Flu Vaccine Recommendation Changed
- Help Keep New Moms Healthy
- PCC Plan Activities Update (PCC Satisfaction Survey)
- PCCs Help Streamline Prior Authorization

Fall 04

- The Quality Improvement Cycle in Action
- Changing your Practice Information
- Trying Your Patience: Dealing with Challenging Patients
- Consumers Direct Advertising Poses Challenges

Winter 05

- Easy Access to Care Benefits Patients with Chronic Conditions
- How are We Doing? The PCC Plan Wants to Know.
- Tips for Reducing Pharmacy Costs
- New Tool Access Patient Prescription Information

Spring 05

- FST Services for Extra Family Support
- Reminder: Did you know that breast pumps are available as a PCC Plan benefit for members who are medically separated from their babies?
- Periodontal Disease and Adverse Pregnancy Outcomes
- Off-label Prescribing

(See Attachment 2 in Appendix B for copies of the SFY05 editions)

PCC Plan Health Education Materials Catalog: The PCC Plan, via the PIMS vendor, issued two volumes of the catalog during SFY05. This catalog features materials developed by the PCC Plan, including a short description and a picture of the material. Materials cover a range of topics to support quality improvement initiatives related to the PIMS. PCCs can order materials from the catalog free of charge through the PIMS PCC Hotline. The catalog also features a reference section that refers the PCC to other agencies or organizations that provide additional support materials or general help for providers.

The Regional Network Manager continues to distribute the catalog to PCCs receiving semi-annual site visits. Furthermore, in an effort to make the materials available to all PCCs, the catalog was sent to all PCCs participating in the Plan in SFY05.

(See Attachment 3 in Appendix B for copies of the catalog)

Member Education Activity: The *Health Highlights Newsletter,* produced by MBHP through the PIMS program, is a bilingual publication (English and Spanish) designed to provide news about the PCC Plan for PCC Plan members. The topics covered in these publications during SFY05 are listed below.

February 2005:

- Mothers are special too
- Depression: Warning signs and treatment
- When do I call the Emergency Service Provider (ESP)?
- Protection from cold weather
- Developing a Crisis prevention plan
- Member Handbook now available
- MassHealth introduces new program for seniors

In 2005, a Health Highlights summer issue was not produced and the next issue will be a Fall/Winter 2006 issue. The Health Highlights newsletter will continue to be produced and distributed two times a year in SFY06.

Also, in SFY05, the PCC Plan continued distributing the PCC Plan Member handbook that was designed to assist PCC Plan members in understanding their rights and responsibilities as PCC Plan members, and how to access care within the PCC Plan. The PCC Plan is also in the process of revising the PCC Plan Member Handbook to be in compliance with the BBA.

(See Attachment 4 & 5 in Appendix B for copies of *Health Highlights* and the PCC Plan Member Handbook distributed in SFY05)

PCC Plan Children with Special Health Care Needs: PCC Plan staff continue to work with other state agencies and providers to define a systematic approach to focus on children with special health care needs (CSHCN) within health care delivery systems. Expected outcomes include exploring ways to target and measure QI efforts and to inform the distribution of a newly developed resource manual for CSHCN and their families. The resource manual, *Directions*, available in English and Spanish, is included in the PCC Plan Health Education Materials Catalog for distribution to families in the PCC's office.

Staff from the PCC Plan continue to participate in the Consortium for CSHCN. This is a group of providers, advocates, and consumers, along with staff from state and private agencies who work to share information and education about ways to best serve CSHCN. The group also focuses on efforts to further the federal Maternal and Child Health 2010 goals related to CSHCN.

PCC Plan Care Management Programs: In SFY04, MassHealth, through its contract with MBHP, implemented a medical care management program called Essential Care, which targets certain MassHealth Essential members. This care management program uses both registered nurses and medical licensed social workers who are assigned to PCC Plan members who meet clinical criteria for participation. The care managers provide education on the members' medical conditions, appointment scheduling assistance and reminders, self-help tips, and access to additional available community resources. The care manager helps to coordinate the services of the primary care clinician (PCC), behavioral health providers (MBHP), hospital emergency departments, specialists, state agencies, and community services. In addition, the Essential Care program uses predictive modeling to identify potential high-cost cases, decision support, and member tracking software.

> *Update:* The Essential Care medical care management program has continued through SFY05 and will continue through SFY06. An evaluation was anticipated to be completed in January 2005; however, to improve the reliability of the evaluation results, the evaluation was delayed to gather data over a longer period of time. The evaluation is expected to be completed in SFY06.

PCC Site-Based Care Management Pilot Program: The PCC Plan administers the PCC Plan Site-Based Care Management Pilot Program by contracting with the Massachusetts Behavioral Health Partnership. This program offers a registered nurse or nurse practitioner care manager located on-site at the Brightwood Community Health Center in Springfield (a PCC office) to up to 400 PCC Plan members who meet certain clinical criteria. In general, these members have complex chronic conditions and/or disabilities, or are diagnosed with HIV/AIDS. The care manager coordinates a team of providers, including the pilot enrollee's PCC and a behavioral health clinician, who work together to plan, deliver, coordinate, and monitor care for the enrollee. The care manager works with the team to develop an Individual Care Plan (ICP) for each pilot program enrollee. An additional component of the program requires a care manager

from the program staff to be available by phone to the pilot program enrollees and their providers 24 hours a day, seven days a week.

> *Update:* This program has continued throughout SFY05. An evaluation of the program was performed by the Center for Health Policy and Research (CHPR) in SFY05. Staff is currently reviewing the evaluation results and anticipates modifying the program design accordingly during SFY06.

MBHP Care Management for PCC Plan Members: In SFY05, MBHP continued to provide three levels of care management. These levels include targeted outreach, care coordination, and intensive clinical management for members with complex or multifaceted behavioral health conditions, substance abuse, medical co-morbidities, and treatment non-compliance.

Managed Care Organization (MCO) Program: The MCO Program covered a wide range of activities during SFY05 including the following highlights:

Continued Quality Improvement Activities: MCO Program staff continued to negotiate and evaluate MCO performance on QI goals; implement the Independent External Review of MCOs ("Clinical Topic Reviews"); and participate in and lead the MCO-related activities for the MassHealth managed care quality measurement activities, such as the collection of Health Plan Employer Data and Information Set (HEDIS) information.

Pilot Program for Children in Foster Care with Special Health Care Needs:
EOHHS and the Department of Social Services (DSS) co-sponsor a pilot program to enroll children who have special health care needs and are living in foster care at the time of initial program enrollment into Neighborhood Health Plan (NHP). The "Special Kids ♥ Special Care" Pilot Program, which began enrollment in December 1999, provides a Nurse Practitioner to each enrolled child to provide and/or arrange for a full range of medical services to be delivered in the child's foster home or other appropriate settings when medically necessary. The nurse practitioner works with the child's DSS case manager, foster family, and primary care physician to develop an individualized medical care plan and arrange for the child to obtain necessary care and services. The DSS case manager remains responsible for the delivery of social services and other non-medical supports, in order that a full range of medical and non-medical services is being provided to the child.

During SFY05, EOHHS, DSS, and NHP have continued to work together to administer each aspect of the pilot program, including screening potential applicants, facilitating the application process, implementing the model of care delivery, and enrollment and disenrollment activities. As of the end of SFY05, the pilot program was actively serving 98 children residing in the Boston/Metro, southeastern, northeastern, and central areas of the Commonwealth. Screening for potential enrollees is ongoing.

MCO Enrollment

The following table (Table 4) compares enrollment in the four MCO plans as of July 1, 2005 with enrollment on July 1, 2004.

Table 4
Comparison of Enrollment in the MCO plans
July 1, 2004 and July 1, 2005

Health Plan	Enrollment as of July 1, 2004	Enrollment as of July 1, 2005	Percent Change from Previous Year
Neighborhood Health Plan	90,010	99,154	+9%
BMC Health Net Plan	117,732	152,931	+23%
Network Health	61,003	71,253	+14%
Fallon Community Health Plan	8,629	9,380	+8%

Boston Medical Center HealthNet Plan (BMCHP) and Network Health MCOs: In SFY05, EOHHS continued to work collaboratively with the BMCHP and Network Health to help increase enrollment in these MCOs. In July 2005, Network Health expanded into the Beverly and Gloucester service areas in the northeastern region of the state. BMCHP also expanded its service area to include Attleboro, in the southern portion of the state, in August 2004, and Barnstable and Falmouth, on Cape Cod, in April 2005. As a result of these service area expansions for both BMCHP and Network Health, and in conjunction with ongoing enrollment and outreach activities, membership continued to increase in the two plans during SFY05. As of July 1, 2005, BMCHP represents approximately 46% of MCO Program enrollment and Network Health represents 21% of MCO Program enrollment.

Quality of Care Activities: In SFY05, both BMCHP and Network Health continued to fully participate in all of the ongoing quality improvement activities conducted by the MassHealth MCO Program. For example, both plans established individual MCO Quality Improvement Projects (QIP) activities, participated in the workgroups around the Standard goals, and were evaluated in the MCO Program's semi-annual Contract Status Meetings.

Both of these MCOs also participated in the MassHealth HEDIS measurement activities and the Independent External Quality Review (Clinical Topic Review) conducted with MCO and PCC Plan during the year.

CommonHealth: MassHealth CommonHealth provides benefits to working and non-working adults with disabilities, as well as children with disabilities who are not eligible for MassHealth Standard (because of income). There is no income limit for CommonHealth; however, non-working disabled adults are required to meet a one-time means test before becoming eligible. CommonHealth allows members to earn an income and access employment. The success of the program is demonstrated by the majority of CommonHealth adult members who have moved from other MassHealth categories into CommonHealth, with a higher incidence of other insurance and a lower average per member per month cost than other MassHealth programs for disabled individuals.

Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities Grant (MICEO): The Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities Grant (MICEO) is a collaboration between the University of Massachusetts and EOHHS aimed at improving employment outcomes for people with disabilities. Funding is used to develop and support comprehensive approaches to promoting employment for Massachusetts's citizens with disabilities who want to work. Awarded in 2003, funding for up to four years (based on availability of funds) will be provided by the federal Centers for Medicare and Medicaid Services (CMS). The overall goal of the grant is to enable people with disabilities to maximize their employment potential by establishing better coordination among current health and non-health care related efforts of state and private agencies. The federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) authorized the national Medicaid Infrastructure grant programs.

Grant activities focus on four key areas:

- *Policy and Budget Development Support* activities focus on providing state policy-makers with information about the CommonHealth program and publicly funded employment services for people with disabilities. For example, at the direction of the Office of Medicaid, the team undertook an evaluation of the CommonHealth program's premium structure. This project evaluated the premium structure by assessing the potential and likely impacts on public assistance program participation and employment, comparing the CommonHealth premium structure to other state and private programs, developing preliminary options for changes to the premium structure, and conducting a preliminary assessment of the likely fiscal and behavioral effects of the proposed options. In addition, the grant is supporting an executive level strategic task force that is implementing a plan to improve employment outcomes. These activities inform executive-level policy decisions and facilitate better program coordination across state agencies;

- *Medicaid Infrastructure* activities involve a series of monitoring and evaluation projects which describe people with disabilities in the state and identify their employment barriers, and which provide a rich source of information to inform state policy leaders and grant strategic work groups. Medicaid Infrastructure activities also include interventions aimed at improving the content and quality of health services for people with disabilities who want to work.
- *Comprehensive Employment Opportunities* involve a joint state agency and consumer grant leadership team to identify strategies and policies that enhance programs and expand opportunities for consumer choice and direction. The CEO is focused on enhancing the capacity of the service delivery system to provide services and supports that lead to employment for individuals with disabilities.
- *State to State Technical Assistance* activities are designed to provide and receive assistance in designing Medicaid Buy-in programs and other employment supports. Massachusetts convenes the Northeast Partnership (NEP) for Health Systems Development as a regional forum of Medicaid Infrastructure grant representatives from Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Massachusetts also participates in two national technical assistance partnerships.

Medical Security Plan: Individuals in Massachusetts who are unemployed, with income up to 400% of FPL, and who are receiving or are eligible to receive unemployment compensation benefits may participate in the Medical Security Plan, offered through the Division of Unemployment Assistance (DUA). The DUA contracts with Blue Cross and Blue Shield of Massachusetts to administer the program and provide utilization management services. The Commonwealth receives FFP under the Demonstration for this program.

The Medical Security Plan provides two different health insurance programs: Premium Assistance and Direct Coverage. Premium Assistance can provide partial reimbursement for premiums paid to continue a health insurance plan whose coverage began while the individual receiving unemployment benefits was still employed (COBRA). The MSP member will be reimbursed at 80% of the actual premium paid (rounded to the nearest $10) up to a cap established for both family and individual plans. The maximum reimbursement, which is set by regulation, is $790 for a family plan and $360 for an individual plan.

Direct Coverage is available to income-eligible individuals who have no access to health insurance benefits. They are provided with health care services, and are responsible for co-pays and deductibles. The applicant is enrolled in an indemnity plan and eligible to receive health insurance benefits through Blue Cross and Blue Shield of Massachusetts. If an applicant does have the option of continuing an existing health plan, they may qualify for a hardship waiver for participation in Direct Coverage.

For the year ending August 31, 2005, the monthly average number of primary enrollees (i.e. the person collecting unemployment insurance) was 2,326, with 1.927 dependents enrolled. Forty-nine percent (49%) of the primary enrollees elected the Direct Coverage option and fifty percent (50%) were enrolled in Premium Assistance.

Provider Services Update:

MassHealth Provider Services Call Center: From July 1, 2004 to June 30, 2005, MassHealth made significant strides to enhance and expand the level of customer service offered to providers. Very often the first call from a provider will be to the MassHealth Provider Services Call Center. The Call Center answered over 240,000 calls, 96% of all calls received, with an average wait time of less than 30 seconds and an average talk time of less than four minutes. Staff continues to receive testing and retraining to ensure accuracy of the information they give to providers.

Research & Support: In addition to provider training activities, provider services continued to expand research and support services to the provider community in the past year. The Research and Support team was created to provide an extra layer of customer service for the provider community. They are assigned referrals not only from the Call Center but also other internal departments at Unisys, EOHHS staff, and other MassHealth vendors such as the Partnership and MAXIMUS. Last year the Research Team completed 2,607 referrals. This team also offers ongoing support to certain provider populations that require additional assistance such as reviewing claims weekly for all Private Duty Nurse providers and contacting them to provide billing assistance.

In addition to training and support activities, the team continues to provide information to providers through several channels, including message text on remittance advices and the creation of new informational flyers. During SFY05, the publications team issued three provider newsletters that mostly focused on the implementation of HIPAA. In addition, 638 publication requests were filed for copies of bulletins, transmittal letters, etc.

Provider Training: During SFY05, providers participated in 154 training events. Of these, the majority were provider-specific trainings for individual providers. These included face-to-face meetings and extensive telephone visits. The majority of these training requests were received through the MassHealth Provider Services Call Center. One-on-one meetings are scheduled for providers needing general billing training. Telephone visits are held when a provider requests a block of time to address a specific area of concern such as billing for Medicare/MassHealth crossover claims, or the eligibility verification process.

In SFY05, materials were redesigned to focus on business process improvements undertaken by MassHealth as well as HIPAA. Provider Services continued to focus on measuring improvement in billing as a result of the trainings. The EOHHS and Provider Services websites were integrated, expanding distribution of educational materials such

as billing tips flyers, a comprehensive frequently asked questions, and provider-type-specific materials.

Training efforts in SFY05 continued to include provider visits, phone calls, large-scale group training (such as when a regulation changes), and ongoing contact with provider associations statewide. In particular, durable medical equipment (DME) providers were targeted for training due to major changes within the DME program. During the year, Provider Services also participated with CMS and provider associations in statewide provider training, focusing on HIPAA and best business practices.

Throughout the year, Provider Services worked closely with EOHHS to integrate the EOHHS and Provider Services web sites (www.mass.gov and www.mahealthweb.com). Provider Services maintained regular contact with all MassHealth provider associations (including coordination of a major publications survey), and participated in MassHealth Technical Forums and billing consultations with the Massachusetts Medical Society. During SFY05, Provider Services trained the following groups: New England Medical Equipment Dealers (NEMED), Massachusetts Hospital Association (MHA), Massachusetts/Rhode Island Medical Group Management Association (MA/RI MGMA), Long Term Care Finance Association (LTCFA), Massachusetts Association of Patient Account Managers (MAPAM), and the Municipal MassHealth Program. Provider Services staff have also worked diligently with the new Customer Service team to ensure a smooth and seamless transition for the provider community.

Compliance with Balanced Budget Act: During SFY05, MassHealth worked closely with staff from the CMS regional office to bring its managed care programs into full compliance with the new Medicaid Managed Care regulations promulgated as a result of the Balanced Budget Act of 1997. These regulations impacted the PCC Plan, the BH Program, and the MCO Program. The areas addressed included:

- Marketing
- Appeals and grievances
- Service authorizations
- Subcontractors
- Access standards
- Provider credentialing
- Care management
- Quality

In addition, as of July 1, 2005, the financial provisions of the contracts with BMCHP and Network Health were brought into compliance with BBA capitation rules regarding actuarial soundness. The capitation rates for the other MCOs and the BH Program were brought into such compliance as of July 1, 2003.

Finally, in order to bring MassHealth's quality programs into compliance with the BBA, MassHealth issued a Quality Strategy and procured an External Quality Review Organization (EQRO) contract to conduct external quality reviews of the MCO, BH

Program and the Senior Care Options (SCO) program. In addition, the EQRO contract includes validation of PCC Plan performance measures.

> *Next Steps*: During FY06, the MCO program, Behavioral Health Program and the PCC Plan staff will work with other MassHealth staff and CMS to develop and begin distribution of member information materials to fulfill the requirements for such member information contained in the BBA regulations. Each relevant managed care contract, and MassHealth's contract with its enrollment broker, currently contains language related to these information requirements, but MassHealth and CMS agreed to a January 1, 2006 implementation date for distribution of the enumerated member information materials.

VII. Family Assistance Premium Assistance and the Insurance Partnership

The MassHealth Family Assistance (FA) Premium Assistance and Insurance Partnership (IP) Programs are designed to make employer-sponsored insurance (ESI) affordable to low-income workers and to encourage and assist small employers in offering health insurance.

- FA offers subsidies on behalf of eligible MassHealth members (children with incomes between 150-200% of FPL and adults working for participating small businesses with incomes at or below 200% of the FPL) to help low-wage workers pay their share of ESI;

- The IP offers subsidies to participating small businesses to help pay for health insurance premiums for low-wage workers and to low-income, self-employed individuals.

MassHealth requires that ESI meet the following minimum requirements to qualify for Family Assistance Premium Assistance:

1. The employer must contribute at least 50% to the cost of the health insurance premium;
2. The offered plan must meet the Basic Benefit Level; and
3. Providing premium assistance must be cost-effective for the Commonwealth.

Key Objectives: Several key objectives have continued to guide development and implementation of the FA and IP programs, including:

- Preservation and promotion of private employer-sponsored health insurance dollars to avoid commercial sector crowd-out;

- Provision of FA and IP premium assistance payments to help low-income families, individuals working for small employers, and self-employed individuals obtain and maintain ESI which would otherwise prove cost-prohibitive;

- Provision of IP employer incentive subsidies to assist in preventing long term decline in the private insurance market by encouraging small employers to offer health insurance coverage and by acting as a “cushion” for small employers who offer coverage to their employees;

- Provision of premium assistance to enable the purchase of family coverage which allows not only the child(ren) but also their parent(s) to obtain coverage;

- Continued utilization and interface with systems, mechanisms, and structures in the private insurance market through contracts with IP vendors including Billing and Enrollment Intermediaries (BEIs) and Employee Benefits Resource (EBR), to work specifically with small business employers.

Administration of Family Assistance Premium Assistance and the Insurance Partnership programs: There are two administrative routes for those eligible for FA and who have access to ESI to obtain premium assistance through MassHealth.

The first route to obtain premium assistance is through the IP for MassHealth eligibles who have access to ESI through a small employer. Two separate operational mechanisms support the IP with usage defined by the type of arrangement the employer has in place.

BEIs serve employers on a range of insurance coverage needs, including the IP. The BEIs conduct enrollment and provide continuing administrative support for very small firms. The BEIs collect information necessary to determine eligibility for the employer, and verify continuing insurance coverage. In addition, BEIs forward employee applications to MassHealth for processing. Incentive payments and premium assistance payments are deducted from an employer's overall insurance bill. Employers are required to adjust the amount withheld for health insurance from the employee's paycheck to account for the premium assistance payment.

Employee Benefits Resource (EBR) administers the subsidies for employers and employees in firms with up to 50 employees, including very small firms and self-employed people who do not buy coverage through BEIs. EBR reviews employer applications, conducts employer enrollment and disenrollment, forwards employee applications to MassHealth, sends subsidy payments to participating employers and verifies continuing insurance coverage. Employers are required to adjust the amount withheld for health insurance from the employee's paycheck to account for the premium assistance payment.

The second route to obtain premium assistance is targeted toward families with income-eligible children who have access to ESI but who do not work for companies qualifying for participation in the IP, primarily because of the size of the employer (over 50 employees). Children are determined eligible to receive premium assistance as a result of an investigative process managed by MassHealth's contractor, Public Consulting Group (PCG). PCG verifies the applicant's employment status and eligibility for insurance and ensures that the ESI meets MassHealth Basic Benefit Level. For families who report to MassHealth that they are currently uninsured, their children are provided MassHealth direct coverage for up to 60 days while PCG conducts its investigation. For both the FA and the IP, if the insurance meets the Basic Benefit Level and the child was previously uninsured, the child is considered S-CHIP eligible.

Current Statistics: As of June 2005, 7,920 policies were purchased through the FA and IP programs. Approximately 52% of the policies purchased were family policies, 41% were individual policies, and 7% were either couple or dual policies. In total, these policies covered 20,416 lives, approximately 41% of which are children.

As of June 2005, 5,153 small employers were participating in the IP program, nearly 72% of those participating were self-employed individuals and nearly 89% employed five or fewer workers. Nearly 47% of those who are self-employed were purchasing a dual, couple, or family policy. As shown below in Table 5, employer enrollment in the IP continued to grow in SFY05.

Table 5
Growth of Number of Employers Participating in the Insurance Partnership from June 2004 to June 2005

Employer Size (# of Full-Time Employees)	June 2004	June 2005	% Increase From June 2004
1(Self-Employed)	3,489	3,696	6%
2 to 5	895	899	0.5%
6 to 9	152	148	-3%
10 to 50	426	410	-4%

(See Chart 3: "Policies Purchased by Type of Policy" and Chart 4: "Lives Covered under Family Assistance Premium Assistance 2005" in Appendix A)

SFY05 Initiatives and Activities: Direct response continues to be the primary marketing tool for reaching small businesses. MassHealth's contractor, EBR, sent over 480,000 mailers to potentially qualified small businesses asking them to fill out a "Quickly Pre-Qualify" form with six eligibility checkboxes. To make responding easy, the company name and address were pre-populated in the letter. If a business was qualified and had at least one qualified employee (as determined by checking the six boxes), they were provided a pre-paid return envelope to send to EBR for program information. Also included were the web site address and an 800-number for immediate information.

Targeted radio, television and billboards were produced and run in the spring of 2005, including:

- Over 1,800 one-minute radio commercials. The commercials primarily featured local area employers (for example, Cape Cod stations played testimonials from local businesses) providing testimonials on how the program has helped them, or their business, purchase or retain health insurance coverage.

- Over 5,000 30-second TV commercials. The commercials were aired in targeted low-income areas utilizing cable TV. Cable TV was chosen for its low cost and ability to target areas most likely to have eligible members.
- 95 billboards (panels) strategically placed around the state.

Other primary marketing activities included working with non-profits such as hospitals, foundations, and outreach workers throughout the state; chambers of commerce, insurance brokers, insurance carriers, and associations; local mayors, and state and local government entities working with low-income residents such as MassHealth, the Department of Economic Development, and the Department of Revenue. Additionally, numerous TV, radio and newspaper interviews were conducted throughout the state – many in foreign languages.

Brochure racks and posters were designed and distributed throughout the state in locations such as hospitals, chambers of commerce, economic development offices, MassHealth, retail chains and other prominent outlets.

VIII. Quality Management

MassHealth employs a variety of methods to monitor the quality of health care delivered by its health plans and members' satisfaction with these plans. For all managed care plans, including the PCC Plan and MBHP, MassHealth requires specific HEDIS measures to assess clinical quality and utilization, conducts an annual Independent External Quality Review, called the Clinical Topic Review (CTR), and conducts a member satisfaction survey. Quality management endeavors that are specific to the PCC Plan and the capitated MCOs, as well as activities common to both, are summarized below.

PCC Plan: The quality management activities for the PCC Plan are derived from goals developed by MassHealth and the PCC Plan. Relevant data from Plan operations, such as aggregate member and PCC data, Profile Reports, HEDIS measures, and the MassHealth Member Survey are used to guide the development of PCC Plan quality improvement efforts. Additionally, the PCC Plan's participation in the Clinical Topic Review in SFY05 did inform additional opportunities for improvement.

The PCC Plan performs quality improvement in various ways, including the production and distribution of PCC Profile Reports, and the development and implementation of Quality Improvement Programs (QIPs). Profile Reports include providing registries of members with specific clinical conditions to PCCs, as well as comparison data on a variety of clinical indicators. The QIPs involve both internal and external stakeholders and have an identified goal to improve the rates/standards of a particular service. Member and provider educational activities are often developed as a part of the intervention for a QIP.

PCC Profiling: The PCC Plan produces its PCC Profile Reports to help PCCs identify areas for improvement, and to identify related improvement interventions. PCC Profile Reports are provided for each PCC practice serving more than 200 PCC Plan members. These PCCs serve 83% of the PCC Plan population. An MBHP Regional Network Manager (RNM) visits each PCC practice receiving a PCC Profile Report to review findings and develop action plans that support quality improvement activities. The PCC Profile Reports are supported by information developed and/or compiled by the PCC Plan Quality Management staff. To prepare for the Profile Report meetings with PCCs, RNMs receive regular updates and training as needed from clinical staff in the PCC plan. This includes information on changes in clinical guidelines and support materials, as well as support in addressing providers' questions and concerns. Some of the areas covered in SFY05 were pap and mammography, Massachusetts Health Quality Partners clinical guidelines updates, immunization guidelines, and new vaccines.

Outlier PCCs, defined as PCCs with less than 200 PCC Plan members who have a large number of members within a certain age or disease category and have a low ranking on one or more PCC Profile Report measures, also continue to receive a PCC

Profile Report and RNM visit. PCC Profile Report measures for outliers are limited to asthma, diabetes, ED, well-child care, and breast and cervical cancer screening. PCCs serving less than 200 PCC Plan members who received a site visit on the previous profile continue to receive a site visit if their current enrollment on or about one month before the profile is prepared is at or above 200 members.

In SFY05, the Profile Report Improvement Meeting (PRIM) workgroup continued to meet biweekly to discuss ongoing quality improvement for the report. SFY05 enhancements made to the PCC Profile Report included a reorganization of the measures into Preventive Care, Chronic Care, and Utilization sections. More detailed member demographics regarding disability status, coverage type, DMH status, length of enrollment, and PCC access were added to the PCC Panel Information section. Guidelines for Women's Cancer Screening were updated to reflect current recommendations per the Massachusetts Health Quality Partners (MHQP) in order to support evidence-based medicine. Lastly, to support root cause analyses of barriers to care, summary information, e.g., enrollment, visits to PCC, and disability status, was added on members who were in compliance with various measures so that PCCs could assess if there are differences between that population and the non-compliant population.

The Reminder Report (RR) continues to list members overdue for well-child care visits, cervical cancer screening, and breast cancer screening, as well as a listing of members with two or more ED visits within the previous six months.

The Care Monitoring Registry (CMR) continues to support PCCs' management of members with chronic disease, i.e., asthma and diabetes, and high pharmacy utilization.

Special programs are available to select populations who may require and be eligible for outreach or care management services in both the RR and CMR.

PCCs select an area(s) for quality improvement from the PCC Profile Report and collaborate with the MBHP RNMs on developing Action Plans that address the planned quality improvement activities. As of June 30, 2005, PCCs had initiated:

- 285 Action Plans related to Well-Child Care;
- 159 Action Plans related to Asthma;
- 204 Action Plans related to Emergency Department Utilization;
- 198 Action Plans related to Cervical Cancer Screening;
- 168 Action Plans related to Breast Cancer Screening;
- 133 Action Plans related to Diabetes;
- 42 Action Plans related to PCC/BH integration;
- 5 Action Plans related to Pharmacy Management;
- 10 Action Plans related to Pediatric BH Screening.

In SFY04, a PCC Profile Report evaluation form was included with the PCC Profile Report. The PCCs were asked to evaluate the Reports (PCC Profile Report, PCC Reminder Report, and PCC Care Monitoring Registry) for content and usefulness. In SFY05, staff reviewed the results of the survey, which revealed that a majority of PCCs found all sections of the Profile report (Care Monitoring Registry, and Reminder Report) useful, with 84% agreeing that they use the profile to improve their practice.

> *Next Steps:* The PCC PR evaluation form will be distributed for the second time in SFY 06 to solicit PCC feedback and trend responses. The PRIM workgroup will use the results to inform future enhancements. The workgroup is also examining the current content and format of the Profile Report and will determine if additional enhancements are needed.

PCC Plan - Maternal and Child Health Activities:

EPSDT: The *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Guidelines Booklet* was prepared in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics. It presents billing scenarios and accompanying questions and answers to provide guidance on how to bill for EPSDT services provided in accordance with the EPSDT schedule. It was mailed to providers who deliver preventive services to children along with the fact sheet, *The Facts-Well-Child-Care Screening and Diagnosis Services*, which gives PCCs a brief overview of EPSDT services. This booklet is in the process of being updated to provide guidance for billing using new HIPAA compliant codes.

In SFY04 MassHealth reported an EPSDT participant ratio of 73%. This ratio represents a comparison of the number of children and adolescents who were due to receive a screening within the reporting period with the number who actually received age appropriate visits. The rate for SFY03 was 71%. Due to a claims lag, the rates for SFY05 are unavailable at this time. Multiple efforts described below serve to support the provision of EPSDT services to MassHealth members under 21 years old.

Immunization Activities: *Continued distribution of Missed Opportunities in Childhood Immunization*. This brochure was developed as a collaborative effort between MassHealth, the Department of Public Health's Massachusetts Immunization Program (MIP), and the UMass Center for Health Policy and Research (CHPR) after missed opportunities were identified as a problem for pediatricians using CHPR and CTR data. The booklet offers strategies to combat the most common reasons for missed opportunities in childhood immunizations. This publication is available in the PCC Plan Health Education Materials catalog.

> *Next Steps:* Assess interest and need for updating this publication in collaboration with the MIP, MCOs or other entities.

Immunization Material Distribution: Immunization-related materials are available to PCCs through the PCC Plan Health Education Material Catalog, including some materials developed by the Massachusetts Chapter of the American Academy of Pediatrics, e.g., Reminder Recall Cards and Vaccinate Me Today Stickers. Immunization updates are e-mailed regularly to providers on the MIP listserv and hard copies of vaccine schedules are mailed to all providers statewide annually with the clinical guideline revisions.

Improving Relationships between PCC Plan and School Based Health Centers (SBHCs): PCC Plan staff continued to strategize with the DPH SBHC program on how to improve communications between MassHealth and SBHCs. The goal is to facilitate a better exchange of information, to improve the quality of care for shared patients, and for MassHealth to utilize SBHCs as an outreach point to link adolescents to primary care.

Governor's Adolescent Health Council: MassHealth also participated in the Governor's Adolescent Health Council, which includes representatives from many different organizations involved in adolescent care. Staff continue to participate in this council, which offers an opportunity for the identification of improvement strategies, shared resources, and communications.

Perinatal Care Quality Improvement Project (PQIP): PQIP is a MassHealth workgroup established to improve perinatal care for members enrolled in the PCC Plan through quality improvement initiatives. PQIP is charged with developing strategies and implementing activities to improve the delivery of health care. Several divisions of the Department of Public Health are integral members of this workgroup, including the WIC, perinatal, and primary care divisions.

Member and Provider Education Activities: In SFY05, the PCC Plan continued to develop, evaluate, update, and distribute educational materials for members and providers with a focus on the promotion of early entry into prenatal care, making and keeping appointments, achieving a healthy lifestyle, postpartum care, and the link to dental care. All materials for members are available in at least Spanish and English.

Materials distributed in SFY05 include:

1. "**Healthy Pregnancy Guide**": a 20 page booklet that provides comprehensive information on prenatal and postpartum care for members. Available in the PCC Plan provider catalog, WIC offices, and Community Health Centers.

2. "**Moms Are Special Too**": a flyer that is included in a monthly WIC mailing to every woman in the Commonwealth who has a live birth. This flyer encourages women to go for their 4-6 week postpartum visit.

3. "**Recipe for a Healthy Baby**": a colorful guide that explains the reasons for early prenatal care. This guide is mailed to all women who identify themselves as pregnant upon MassHealth enrollment and is also available in the PCC Plan Catalog.

4. **Massachusetts Health Quality Partners (MHQP) Perinatal Guidelines (2004)**: These guidelines have been endorsed by MassHealth and twenty other major health plans and provider organizations. The guidelines were developed to assist providers in delivering consistent, high quality, and evidence-based perinatal care. A copy of the guidelines is available through the PCC Plan Health Education Materials Catalog and on the MassHealth website.

5. "**After Your Baby is Born, Your Postpartum Visit**": a brochure that explains the reasons for the 4-6 week postpartum check-up and encourages members to make and keep appointments. Pediatric providers are encouraged to distribute it to remind new mothers when they come to the office with their babies.

6. **Postpartum Reminder Card** for use by providers to remind women to make or keep their postpartum visit appointments.

7. "**Choosing a Doctor or Nurse for Your Child**" encourages pregnant women and new mothers to choose a doctor or nurse for their babies as early as possible and offers tips on how to choose.

8. **Obstetrical Risk Assessment Form**: a practice management tool used to identify women at risk for pregnancy complications or those who may need additional support during pregnancy.

9. "**Pregnancy Oral Health Tidbits**": a newly developed fact sheet published in conjunction with a grant-funded project of a MassHealth provider which reinforces the message of good oral hygiene and good pregnancy outcomes for mother and baby.

> *Next Steps:* PQIP is in the process of revising the postpartum brochure to target women who bring their children to the primary care provider's office for two- and four-week check-ups. This strategy was based on HEDIS and CTR reports, which showed that women are diligent about bringing their children to the pediatrician's office for early check-ups. The revised postpartum brochure will be mailed to pediatric and family practice offices and community health centers with a letter requesting their assistance in reminding new mothers about the importance of this visit. The PQIP will continue to regularly publish articles in both the provider newsletter and the member publication on topics related to perinatal health (see section on newsletters).

PCC Plan-Diabetes: Diabetes care for PCC Plan members was identified as an area for improvement in 1999. Since then, multiple initiatives have been undertaken. SFY05 initiatives include:

- Development of a "Diabetes and Depression" fact sheet for members. As evident in clinical literature, members with diabetes have a higher incidence of depression. The fact sheet supports the integration of medical and behavioral health.
- Results of the HEDIS 2004 Comprehensive Diabetes Care Measure were evaluated, and one area identified for improvement was screening for retinopathy. The QM Unit formed a workgroup, including experts in the area of diabetes management and treatment, and developed a proposal to implement processes to increase screening for retinopathy. The QIP will be implemented in SFY 06.

Collaboration with the Diabetes Prevention and Control Program (DPCP) (Massachusetts Department of Public Health):

- *The Massachusetts Guidelines for Adult Diabetes Care 2005* were updated and completed in June 05. The Guidelines are promoted to PCCs as the standard of care for PCC Plan adults with diabetes.

- *Diabetes and Flu Brochure:* In the fall of 2004, the PCC Plan collaborated with the DPCP to mail a brochure titled "If You Have Diabetes, a Flu Shot Could Save Your Life" to all PCC Plan members identified as having diabetes.

PCC Plan - Asthma: The PCC Plan continues to educate PCCs regarding the National Heart, Lung, and Blood Institute's (NHLBI) Guidelines for the Diagnosis and Management of Asthma. In addition, the PCC Plan collaborated with MHQP to develop and implement the Massachusetts Asthma Action Plan (AAP), and a QI initiative was developed and implemented in SFY05 as well. The AAP and other asthma educational materials were mailed to pediatric members identified as having persistent asthma. PCCs also received a mailing which instructs them to complete the AAP for members when they present in the ambulatory care setting. This QIP supports the NHLIBI Guidelines by encouraging PCCs to prescribe controller medications to members with persistent asthma.

PCC Plan Adult Preventive Care: The *MHQP Adult Preventative Care Guidelines Poster* was updated in FY05 by Massachusetts Health Quality Partners (MHQP), a broad-based coalition of health plans, health-care providers, purchasers, and government representatives working together to promote improvement in the quality of health-care services across the Commonwealth. The Guidelines are available to all providers for use in their offices. The PCC Plan distributes the Guidelines Poster through the Catalog and has adapted a summary of the Guidelines, which was made

available to PCC Plan providers for use as a desktop reference, laminated with the MHQP Pediatric Guidelines on the reverse side.

PCC Plan Behavioral Health Program: As a part of ongoing quality management, MassHealth regularly receives data from MBHP that measures continuing care rates, access to aftercare services, readmissions, claims processing times, telephone answering information, and a broad array of service utilization details.

Several special projects were undertaken during SFY05, including:

- MBHP implemented a statewide program to expand the ability of child psychiatrists to provide consultative services, including psychopharmacological services, to the pediatric community. Known as the Massachusetts Child Psychiatric Access Program, this program was built through the cooperation of MBHP, PCC Plan, the MassHealth Medical Director, and the University of Massachusetts. The program's goals are to improve access to child psychiatry for PCCs throughout the Commonwealth and to improve the quality of psychotropic prescribing for children. This program is available to children through all insurance plans. Six regional teams, comprised of a psychiatrist, a social worker or psychologist, and a care manager, are contacting PCC practices to enroll them in the program. PCC enrollment means participating in an orientation / information session and meeting with the consultation team. As of August 2005, 475,000 children under age 18 are covered through their participating PCCs and the regional teams are continuing to enroll additional PCC practices.

- MBHP collaborated with DMH to address the special primary medical health care needs of DMH clients who receive case management services. Specifically, DMH and MBHP identified diabetes as the target for an improved case management protocol. An educational forum was held and was attended by DMH clients with diabetes, DMH case managers, MBHP staff, PCCs, consultants in diabetes management, and residential providers. Feedback from this educational forum will be formulated into an improved case management protocol for DMH clients with diabetes. This protocol will be rolled-out to all DMH case managers in SFY06.

- During SFY04, MBHP collaborated with a broad spectrum of stakeholders, including the consumer advocate community, to conduct a feasibility study for the development of a "Recovery Learning Center" (RLC). During SFY05, MBHP continued to work with the stakeholder group to refine the program model. DMH reviewed the feasibility study and decided to fund a pilot RLC that would be developed under the auspices of DMH and with consultation from MBHP. Specifically, MBHP was asked to conduct an organizational readiness assessment for the consumer-run vendor (M-POWER) that was chosen to

develop the RLC. MBHP will continue to provide management consultation to M-POWER as they develop the RLC pilot program.

- MBHP collaborated with DMH, Corrections (DOC), Public Health (DPH), and the Bureau of Substance Abuse (BSAS) to support the Massachusetts Parole Board in developing new strategies for addressing the health care needs of offenders transitioning from prisons back to the community. Toward this end, MBHP: convened and facilitated a multi-agency task force; developed and piloted an "Health Care Access Protocol" to capture medical and behavioral health information relevant to accessing community-based health care; improved the eligibility process to ensure Medicaid benefits for offenders entering the community; developed a care management tracking system for eligible offenders; and developed work plans for each of the Regional Reentry Centers to implement these new protocols.

- During SFY04 and SFY05, MBHP collaborated with the Department of Mental Retardation (DMR), DMH, and DSS in an effort to better understand the unique needs of children adolescents and adults with "dual diagnoses" (MR/MH) and to make system improvements to increase access to behavioral health services for PCC Plan members with dual diagnoses. As a result of a statewide conference co-sponsored by DMR and MBHP that was held in SFY04, DMR and MBHP have implemented quarterly regional meetings between DMR and MBHP staff to assess the local issues regarding access and service delivery to members with dual diagnoses. These regional meetings have become a routine part of the ongoing DMR/MBHP collaboration. In addition, MBHP organized a conference that was attended primarily by psychiatrists and PCCs who reviewed and gave feedback to DMR about their draft psychopharmacology standards for people with dual diagnoses.

- In collaboration with the Department of Transitional Assistance (DTA), the Massachusetts Housing Alliance, DSS, DPH, DMH, and MassHealth, MBHP is working to improve the access and coordination of behavioral health services for members and their families that have a history of homelessness. MBHP has developed a homelessness needs assessment tool that will be used by all stakeholder agencies for the purpose of identifying the clinical and non-clinical services for homeless members. In addition, MBHP is collaborating with DTA to improve health care access for homeless members who obtain housing through the Commonwealth's Housing First program. MBHP has piloted a behavioral health training curriculum for Emergency Assistance Shelter providers and agency case workers that assesses members' readiness to change and trains staff in making behavioral health service referrals. This clinical support for the Housing First program will be expanded by MBHP during SFY06.

Quality Improvement and Advisory Council Meetings: In SFY05, MBHP continued a number of councils that meet periodically throughout the year. In SFY04, there was a

continuing emphasis placed upon developing and maintaining interaction between these various councils. Conjoint council meetings are scheduled throughout the year.

The Family Advisory Council meets monthly to engage in discussions of program information, helping monitor the contractor's performance with special emphasis placed on behavioral health care services provided to families and children. This council is made up of family members of adults and children either biologically related, in a foster care arrangement, or in an adoptive family. This group includes representatives from MassHealth, DSS, the Massachusetts Chapter of the National Alliance of the Mentally Ill, and the Parent/Professional Advisory League.

MassHealth's *Consumer Advisory Council* has been meeting since the contract's inception, and continues to meet on a monthly basis. This group of approximately 20 behavioral health care consumers' reviews programmatic information, offers advice and suggestions for consumer-focused performance standards, and helps to monitor the contractor's progress toward annual improvement goals. MassHealth and DMH have representatives within this council. In SFY04, a council workgroup developed and delivered a proposal that was eventually incorporated as one of the selected performance incentive initiatives for SFY05.

The *Behavioral Health Advisory Council* continued to meet throughout SFY05, with representatives from DMH, MassHealth, trade organizations, academia, consumers, and family members. The Behavioral Health Advisory Council meets every other month. The goal of this group is to review programmatic information, assimilate that information with knowledge from their diverse range of experiences, and offer constructive criticism about the Behavioral Health Program to the contractor and the MassHealth.

The *Behavioral Health Clinical Advisory Council* is comprised of local area practitioners who represent various cultural/ethnic groups and various service types within the mental health and substance abuse treatment community. The Council is chaired by the BH Program Medical Director, and meets at least quarterly to address a variety of clinical and administrative issues. A conjoint meeting with the PCC Clinical Advisory council is held once a year to address issues of shared concern. The Behavioral Health Clinical Advisory Committee assists in the development and implementation of clinical and level-of-care guidelines.

Alerts: Alerts are high-level policy directives distributed by MBHP to all network providers with a goal of improving services. For example, in SFY05, a series of alerts were issued relative to the continued implementation of the Clinical Outcomes Measurement Program.

Department of Mental Health-Affiliated PCC Plan Members:

Continued providing of DMH member level medical service data to "primary" behavioral health providers was interrupted while legal concerns over confidentiality issues were

reviewed by MassHealth and MBHP legal staff. We are hopeful that these legal issues will be resolved so that such information can be shared again starting in 2006.

All behavioral health providers with over 200 MBHP members continued to have the well-child visit rate for their pediatric members included in their outpatient profiles. These profiles show the actual well-child visit rate as well as the quartile relative to their peers. The network managers are getting excellent feedback from the providers on the utility of this information. Using this information, one individual bilingual provider with a mostly Latino population brought their rate from 57% to 89%. This is a change from the first quartile to the fourth, or top, quartile. 89% is actually a best practice, being over the 90th percentile. We are now ready to trend the utility of this information across the network. This effort will also be helped by the resolution of the confidentiality issues so that MassHealth can provide the names of actual members needing services to BH providers.

MCO Program Quality Improvement and Measurement Activities: The MCO program continued to focus its quality improvement and measurement activities on Standard and Plan-Specific MCO Quality Improvement Goals, HEDIS measures, Clinical Topic Reviews (CTR), and member satisfaction surveys. HEDIS, CTR, the member satisfaction survey, and other common QI activities that are conducted in conjunction with the PCC Plan and Behavioral Health Program are addressed in the sections below.

MCO Quality Improvement Goals: MassHealth continued to oversee the MCOs' Standard and Plan-Specific Quality Improvement (QI) Goals, included in MCO contracts and described below. For this QI cycle, which consisted of 12 months aligned with the SFY, each MCO submitted mid-cycle and final written reports addressing progress, barriers, and new knowledge gained for each Standard and Plan-Specific Goal, in addition to presenting on these areas during final meetings with MassHealth staff. MassHealth provided written feedback to MCOs following mid-cycle and final submissions and, at the culmination of the QI cycle, scored each MCO on its performance relative to QI objectives, as well as on other contract management and reporting requirements. MassHealth involves a team of MCO and PCC Plan staff with expertise relevant to the clinical and QI initiatives undertaken by the MCOs in reviewing MCO performance.

> *Next Steps:* Standardized QI Goals, objectives, and measures were implemented for the July 1, 2005-June 30, 2006 QI cycle. Consistent with previous processes, MCOs will submit mid-cycle written reports, final written reports, and host final presentations for MassHealth staff. Each MCO will be scored on each goal component at the culmination of the cycle.

Standard Improvement Goals: During FY05, the MCO program continued to negotiate Standard Quality Improvement Goals in selected areas, which all contracted MCOs were required to address. Standard Goals for the 12-month 2004-2005 cycle included:

- *Maternal and Child Health (MCH):* The MCH Goal was designed to be a multi-year effort, providing the opportunity for focused interventions in three areas: *perinatal care*, *immunizations,* and *adolescent anticipatory guidance*. This multi-year strategy allowed time for data collection and implementation of strategies in each of these three challenging areas, and provided the ability to utilize information from other data sources, namely HEDIS and Clinical Topic Review (CTR). HEDIS and CTR are rotated to provide data for benchmarking and evaluation.

  To support MCH-related initiatives, a MCH Workgroup, also referenced in the QI Workgroup section below, consisting of representatives of each MCO, the PCC Plan, and several divisions of the Department of Public Health, developed and shared strategies to improve care for perinatal women and children.

- *Special Populations (SP):* The sixth year of the SP Goal provided the opportunity for MCOs to continue to build upon the progress made during previous years. MCOs sought to identify MassHealth members with special needs, understand their needs, track the care provided to them, and focus on a specific population with targeted intervention strategies. The Goal for the 2004-2005 cycle consisted of two ongoing components: *Population Focused Care* and *Care Management.*

  To support SP-related initiatives, a SP Workgroup, also referenced in the QI Workgroup section below, was convened to share best practices relating to care management of MCO members. MCO Program staff, who organize and facilitate these meetings, invited speakers with knowledge about community-based resources that are available to support MCO staff in their care-management initiatives.

Plan-specific Goals: During SFY05, the MCO program continued to negotiate two Plan-Specific Goals with each MCO. These goals varied significantly and addressed such topics as: pediatric and adult asthma, diabetes, breast cancer screening, tobacco cessation, member satisfaction, and cultural competency.

Quality Improvement Workgroups: To support the above Standard Goals, EOHHS convened and led MCO Maternal Child Health and Special Populations Workgroup meetings (described in the QI Goal section above) regularly throughout the QI cycle. In addition, EOHHS facilitated meetings with MCOs pertaining to other QI and QM initiatives.

Evaluation of MassHealth Rating Categories III and IV: MCO Rating Categories (RC) III and IV provide specialized managed care services to people with active or advanced AIDS (RC III) and severe physical disabilities (RC IV) and have been programs provided through MassHealth since the inception of MassHealth Managed Care in 1992.

Prior to SFY 2004, EOHHS asked the UMass Center for Health Policy and Research (CHPR) to conduct a comprehensive evaluation of these special MCO-contracted care management programs, in part, to respond to a need for cost and program impact information to inform a future managed care organization re-procurement process. Final reports were presented to EOHHS in March 2004. An additional quantitative analysis focused on the cost-effectiveness of the RC IV program was delivered to EOHHS in July 2005. .

RC III: CHPR reported that the RC III program was meeting objectives to deliver and coordinate a broad array of services to a medically and psychosocially complex patient population with diagnoses of HIV/AIDS. Informant interviews affirmed the value of the care delivery and care management delivered by dedicated clinicians, as well as the role of the nurse practitioner being a key factor to the level of satisfaction on the part of program enrollees. In addition, enrollees reported improved access to individualized care. Program clinical staff indicated success in achieving medication adherence and behavior changes with the population served, through home visits and empathetic and effective communication with enrollees.

RC IV: CHPR reported that the RC IV program was reducing barriers to health care for individuals with severe physical disabilities and is achieving integration of care as well as helping enrollees to live in the community as independently as possible, despite their complex medical needs. Interviews affirmed the value of the primary and preventive care and care coordination delivered by an expert team of clinicians, and the value of the relationship between the nurse practitioners and enrollees, which, again, appears to be a key factor to the high level of satisfaction with the program. “24/7” availability of the nurse practitioners contributed to the program’s success in improving access to care and reducing the number and intensity of secondary conditions for program participants.

The additional quantitative reporting provided by CHPR showed that, while identifying an appropriate comparison group for purposes of comparing claims data and utilization proved very challenging, the program appears to reduce and prevent inappropriate emergency department use among enrollees; reduce the frequency of hospitalizations (even though once hospitalized, members stay longer); reduce preventable hospitalizations; and shows that per person, program expenditure is comparable to that of other MassHealth wheelchair-users in Boston, and lower than that of other comparison groups.

The programs continue to serve MassHealth MCO members who meet clinical criteria for participation.

Maternal and Child Health Quality Management Activities Common to Both the PCC Plan and MCOs:

MHQP Pediatric Preventive Care Guidelines 2005 Poster: The poster was compiled by MHQP, a broad-based coalition of health plans, health care providers, purchasers, and

government representatives working together to promote improvement in the quality of health care services across the Commonwealth. The poster's recommendations reflect the requirements of the MassHealth EPSDT Medical Protocol and Periodicity Schedule. A summary of these guidelines has been developed and printed on laminated heavy paper for easy desktop reference for providers, with the adult guidelines printed on the reverse side. The poster and summary were mailed to all pediatric providers in the Commonwealth and is available upon request. It is also used to provide guidance to Head Start, Early Intervention, School Based Health Centers, and WIC staff, among others who care for children. There is an electronic link on the MassHealth website to the MHQP website for quick and easy access for providers.

In addition, MassHealth staff presented the MHQP Guidelines and EPSDT Medical Protocol and Periodicity Schedule at a national meeting of state EPSDT coordinators. The discussion centered around the consistency of the guidelines for all Massachusetts providers, including those delivering services to MassHealth members.

Healthy Start/Grow Smart Booklet Distribution: Starting in December 2003, a series of 13 booklets on infant growth and development were mailed to all women on MassHealth who delivered babies. These booklets are provided by CMS and mailed by a subcontractor supported by a grant from CMS. The first sets of seven booklets were mailed out each month to newly-delivered mothers and an age-appropriate second set was mailed at the infants' six-month birthday.

> *Next Steps*: Continued funding for this project was approved for SFY06 and SFY07. Expansion to 13-24 months and additional languages are planned.

Women, Infants and Children (WIC) Nutrition Program Initiative: A formal agreement between MassHealth and the WIC Program has been developed to facilitate an exchange of data that will enhance the outreach to MassHealth members who are also eligible for WIC benefits. MassHealth member data for members who have indicated that they are pregnant and infants and children under 4.5 years was provided to WIC in order to match enrollment files and outreach to those potentially eligible women and children. Postcards were mailed to 77,000 MassHealth members who were not enrolled in WIC, inviting them to call WIC to enroll for benefits. This has been a very successful project and will continue based on the evaluation of response to the WIC call line.

> *Next Steps:* The WIC ISA is due to expire in June 2006. This ISA will be revised or updated based on new knowledge gained since the original document was written.

Additionally, MassHealth staff participates on the WIC Medical Advisory Committee, and WIC staff participates in the MCH Workgroup and the Perinatal Quality Improvement Program.

WIC will present their multi-cultural materials for women and children developed by local staff to the MCH workgroup, allowing the MCOs to incorporate the materials in their

efforts with providers and members. WIC is visiting the offices of all appropriate providers over the course of the next year; knowledge about this initiative will allow plans to support these efforts and encourage communications.

MassHealth distributes WIC outreach materials to all applicants and includes information about WIC in the EPSDT notices sent to families of MassHealth children. WIC distributes MassHealth enrollment materials in clinics to ensure that all children have an opportunity to access insurance.

A flyer entitled “Moms Are Special Too” continues to be enclosed in the monthly WIC mailings that go to every woman in the Commonwealth who has a live birth. This flyer encourages women to go for their 4-6 week postpartum visit.

Childhood Overweight Prevention and Treatment: MassHealth staff are active partners in the Massachusetts Chapter of the American Academy of Pediatrics Committee on Pediatric Overweight. This committee collaborates with insurers, public health policy makers, nutritionists, and pediatricians to advocate for children in the areas of provider education, public awareness and the development of tools for identification and treatment of childhood overweight. MCAAP held a full day conference for members as a direct result of this effort. This year, MassHealth advocated for WIC participation, and WIC offered multicultural resources and tools for use by the pediatricians in this effort.

Department Of Social Services (DSS) Collaboration: MassHealth and DSS are collaborating with a primary care practice at UMass in Worcester. The FaCES Clinic offers comprehensive services to children entering foster care in the Worcester DSS region. The goal of the project is to assure that all children receive their seven- and 30-day exams and comprehensive EPSDT screenings, referrals and services. The evaluation of this project will inform future direction. Data sets from a previous analysis of the seven- and 30-day visit rates will help provide a framework for this analysis.

MassHealth staff also participates in the activities of a Massachusetts Chapter of the American Academy of Pediatrics committee that seeks to identify areas in which physicians can collaborate with state agencies to improve care for children in DSS care and custody.

> *Next Steps:* Developing a quality improvement effort in collaboration with DSS that will be aimed at improving the rate of health care visits at seven and 30 days after placement in DSS care and custody.

Early Hearing Detection and Intervention: Collaborations were strengthened in SFY05 with the DPH Department of Newborn Hearing Screening and Referral. MassHealth staff attended a national conference where numerous state and federal staff learned how agencies can work together to improve on-going follow-up and screening. As a result, a state roadmap was formulated and interagency trainings have been planned as well as dialogue on billing, authorizations and other barriers to care.

Next Steps: Training will be held for Child Care Health Consultants and Head Start and Early Head Start health coordinators in MA in conjunction with vision screening staff from DPH responsible for pre-school vision screening and follow-up. The goal is to improve communications, improve screening rates and follow-up for children who have vision and hearing deficits.

Child and Adolescent Health Measurement Initiative: This national group works toward developing and implementing measurement tools for child and adolescent health. MassHealth staff actively participate on the Executive Committee of this initiative and provide input from the Medicaid perspective. In SFY05, the initiative's focus was on the Promoting Healthy Development Survey (PHDS) and the data on CSHCNs available on the CAHMI website. The PHDS will be implemented in the MassHealth plans in 2005 for Clinical Topic Review. The results of this survey will provide data for quality improvement projects on the plan and provider level focused on developmental and behavioral anticipatory guidance and care for young children.

MassHealth Adolescent Anticipatory Guidance Public Awareness Campaign (MAAGPAC): The PCC Plan, MCOs, the Department of Public Health, and the UMass Access Project joined together to increase the rate at which adolescents have an annual well-child care visit and thereby increase opportunities that providers have to deliver age appropriate anticipatory guidance.

A public awareness campaign was initiated and continued throughout the summer of 2003, consisting of public-transit advertising, posters which were widely displayed indoors and outdoors throughout three Massachusetts' communities, and postcards developed by and for teens 14-16. Additionally, a public service announcement was developed and aired on the Spanish language channel on cable TV.

A toolkit was mailed in September 2003 to 200 community agencies that serve teens. The toolkit included posters and postcards (English and Spanish), a list of frequently asked questions written from the teen's perspective that offer information on enrollment in MassHealth and managed care options, choosing a provider, confidentiality, and other issues important to teens, statistics developed as a call to action, and web and telephone resources.

The evaluation of the campaign has shown an awareness of the media campaign in the areas targeted. Over the same time period, the HEDIS rate for MassHealth teens receiving well care visits rose from 51% in 2001 to 59.3% in 2003, far surpassing the National Commercial rate of 37% and nearly equal to the Massachusetts Commercial rate of 61%. The MAGPAAC efforts may have contributed to this increase in rates.

During SFY05, the MAGPAAC workgroup designed a re-launching of the campaign for SFY06.

Next Steps: Based on this data, the project was expanded and will include transit

advertising in two cities in MA that have high rates of MassHealth teen enrollment, poverty and teen pregnancy. Additionally, with the cooperation of the Director of School Health at DPH, school nurses across the state have been recruited to display posters and distribute bookmarks with a teen-friendly prevention message. This effort will coincide with the beginning of the school year as teens are getting school, sports, and job physicals. The PSA will again air on Spanish-language TV. Following this initiative, an evaluation will be undertaken, consisting of pre- and post- HEDIS rates by zip code in the geographical areas of intervention.

Immunization Activities:

Information Sharing and Collaboration with MassHealth and the Massachusetts Immunization Program *(MIP)*: The MIP continues to collaborate with the MassHealth PCC Plan and contracted MCOs by sharing the results of their immunization assessments. MassHealth and the MIP work together to compile a list of practices in need of an immunization assessment. Staff from the MIP conduct this assessment by performing chart reviews on a sample of the practice's two-year olds, to determine if the practice is successful in ensuring that its two-year olds are fully immunized. With the provider's consent, information from the assessment is shared between the provider and MassHealth and all of the MCOs/PCC Plan that the provider is enrolled with to target immunization quality improvement activities.

Next Steps: MassHealth will continue to nominate practices to the MIP that are in need of an immunization assessment. The MIP staff has agreed to work with MassHealth to prioritize these sites for assessments in the upcoming assessment cycle. Collaboration continues to increase the number of providers consenting to the release of this information.

MIP Childhood Immunization Guidelines: In SFY 05, MassHealth endorsed the DPH immunization guidelines for the sixth year in a row. MIP distributed these immunization guidelines to all providers in the Commonwealth who care for children. MassHealth also promotes the use of the Vaccine Administration Record, a document recommended by the MIP to track immunizations, which includes all of the fields required for compliance with the federal vaccine administration requirements.

Participation in Government Performance Results Act (GPRA) Immunization Activity: GPRA is a CMS-sponsored multi-year initiative to improve immunization rates for two-year olds. Massachusetts entered the project as a phase one state and agreed to a five-year commitment that included three years of measurement. In SFY02, MassHealth submitted its final year of measurement, achieving its final GPRA goal of having 80% of MassHealth enrolled two-year olds being fully immunized. Having completed the measurement component of the project, MassHealth continues to participate in the project as a resource for the other states still collecting data, by attending focus groups

and providing information about best practices and opportunities for collaboration and sustaining progress.

Early Intervention (EI) Partnerships Program (EIPP): Through an Interagency Service Agreement (ISA) with funding from MassHealth, the Department of Public Health administers this community-based perinatal program, which consists of a nurse-led team of home-based support staff serving pregnant and parenting families. Early Intervention Programs are the lead agencies for these services, assuring a strong link of evaluative and treatment services for the infants.

In SFY05, MassHealth staff provided a full day of training for EIPP staff at their regional meeting. Staff presented information on important clinical issues such as the postpartum examination, breastfeeding support, and resources available to pregnant women through MassHealth. Staff from the transportation unit, behavioral health program, PCC Plan, MassHealth MCOs, Healthy Start, and the Children's Medical Security Plan offered a comprehensive overview of each program area and the services available as part of the MassHealth benefit.

MassHealth staff also support this effort by participating on the Postpartum Depression Grant Advisory Board. This grant supports collaborations of WIC, MassHealth, EIPP and providers to promote early identification and treatment of postpartum depression. The revised postpartum brochure developed by the PCC Plan includes a section on signs of postpartum depression and is an example of the combination of these common goals.

Lead Screening: MassHealth staff continue to participate in the Strategic Planning Process with CLPPP and to identify areas that can offer opportunities for improvement. Staff members from the CLPPP attended an MCH Workgroup meeting (the workgroup has representation from the PCC Plan and MCOs) to brainstorm about new areas for collaborations. As a result of this meeting, the CLPPP wrote articles for the plans to include in the provider and member newsletters and the PCC Plan and MCO staff are now more aware of the activities and resources available through the DPH CLPPP.

HEDIS: The Health Plan Employer Data and Information Set (HEDIS) is a set of performance measures for health plans and managed care organizations, developed and maintained by the National Committee for Quality Assurance (NCQA). MassHealth uses a subset of HEDIS measures on a rotating basis to assess the performance of the contracted capitated MCOs and the PCC Plan. MassHealth's rotation of measures centers on clinical quality and utilization indicators, as identified by key stakeholders within MassHealth, and involves selecting preventive, chronic care, and behavioral health indicators.

HEDIS 2004 results were calculated for the following measures: Childhood Immunization Status, Adolescent Immunization Status, Well-Child Visits, Adolescent Well Care Visits, Children and Adolescents' Access to Primary Care Practitioners,

Comprehensive Diabetes Care, Use of Appropriate Meds for People with Asthma, Mental Health Utilization, and Chemical Dependency Utilization. MassHealth's HEDIS 2004 Final Report was completed in December 2004.

HEDIS 2005 measures focused on Breast Cancer Screening, Cervical Cancer Screening, Antidepressant Medication Management, Follow-up after Hospitalization for Mental Illness, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Controlling High Blood Pressure, Appropriate Treatment for Children with Upper Respiratory Infections, Prenatal and Postpartum Care, Frequency of Ongoing Prenatal Care, Adult Access to Preventive/Ambulatory Health Services, and Outpatient Drug Utilization.

The MassHealth HEDIS 2005 analysis will be completed in the middle of December, 2005. This analysis will include comparisons of rates for these indicators against national and regional benchmarks. Additionally, in SFY04 MassHealth ended the process of conducting Behavioral Health HEDIS measures every other year, and began a yearly measurement policy.

Independent External Review: In SFY04, MassHealth again contracted with the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School to perform the MCO Independent External Quality Review, known as the Clinical Topic Review (CTR), for the MCO Program and the PCC Plan. Massachusetts Peer Review Organization (MassPRO) conducted the medical record review related to the selected clinical topics, under a subcontract managed by CHPR. Topics for SFY04 included Diabetes Care and Women's Preventive Health Care, with a final report completed in January 2005.

The CTR for SFY05 included a survey on health development to parents of MassHealth members between the ages of three and 48 months and a review of medical records of survey respondents to supplement information on care obtained through the survey. A final report of the results is scheduled for December 2005.

Member Survey: Historically, MassHealth conducted an annual MassHealth Member Survey for the purpose of eliciting member feedback in a number of areas including availability and access to services, utilization and experience with health services, as well as member satisfaction with the services delivered by their health plan or provider. In 2003, MassHealth received approval from CMS to amend Term and Condition Number 15 of the Demonstration and survey MassHealth managed care members enrolled in either the PCC Plan or an MCO every other year rather than annually. The reasons for this schedule change from an annual survey include: consistency of the results of the surveys since 1998 indicating that members in all plans are highly satisfied with their experience of care; overall ratings since 1998 with little variation from year to year or from plan to plan; few findings that were statistically significant; and statewide financial constraints. As a result of this amendment, MassHealth conducted its member satisfaction survey in the spring of 2004. Analysis of

the survey results was completed and a report of the findings issued in January 2005. The survey will next be administered in 2006.

Encounter Data: Terms and conditions of the demonstration require the Commonwealth to collect and forward, annually to CMS, encounter data on selected clinical indicators for each of its managed care programs: the Managed Care Organization (MCO) plan, the Behavioral Health Plan (BHP), and the Primary Care Clinician (PCC) plan.

MCOs collect and maintain 100-percent encounter data at the plan level for all MCO covered services. This encounter data can be linked to MassHealth eligibility files. MCOs are required to submit their encounter data quarterly and are required to submit one encounter for each service performed. The Behavioral Health Program is required to submit its encounter data to MassHealth on a monthly basis. PCC plan encounter data is collected and maintained directly by MassHealth. MassHealth submits 100-percent encounter data on selected clinical indicators to CMS in July of each year. The following is a list of those submissions.

- July 1998 Submission: Pediatric well visits
- July 1999 Submission: Pediatric Asthma Measures
- July 2001 Submission: Well-Child visits and utilization
- July 2002 Submission: Well-Child visits and utilization and Pediatric Asthma Measures
- July 2003 Submission: Well-Child visits and utilization and Pediatric Asthma Measures
- July 2004 Submission: Well-Child visits and utilization and Pediatric Asthma Measures
- July 2005 Submission: Pediatric Asthma Measure

MassHealth also submits the Minimum Data Set (MDS) for the Encounter Data Project to CMS in July of each year. The following is a list of those submissions:

- FY98 data submitted in July 1999
- FY99 data, including updated MDS for FY98, submitted in July 2000
- FY00 data submitted in July 2001
- FY01 data submitted in July 2002
- FY02 data submitted in July 2003
- FY03 data submitted in July 2004
- FY04 data submitted in July 2005

MassHealth submits encounter data for the PCC Plan and the wrap-around services for the MCO Program to CMS through its Medicaid Statistical Information System (MSIS) on a quarterly basis. The wrap-around services for the MCO Program represent those services required by the MDS that are paid for directly by MassHealth.

MassHealth performs detailed data quality testing of the encounter data for the PCC Plan, the Behavioral Program, and the MCO Program.

The Data Quality Review Process is an iterative one, with MassHealth rejecting and returning claims with errors to the MCOs. The MCOs are then expected to correct the rejected claims and resubmit them. The submission-rejection-resubmission cycle repeats iteratively until the number of rejected claims falls below a MassHealth-defined threshold. As part of each submission, either quarterly or error correction, an error report is generated that outlines the fields with errors and the number of errors for each field.

As part of the ongoing data quality process, MassHealth discusses data quality issues on a regular basis with the health plans. Those issues include the performance of individual data fields and how fields can be improved upon, as well as reviewing invalid values from the data quality reports.

IX. Grievance and Appeal Process

Grievances

PCC Plan
In SFY05, MassHealth members filed 24 grievances against PCC's, PCC practices, or PCC office staff.

MCO Program
In SFY05, MassHealth members filed 1,435 grievances against MCOs, through their MCOs.

Behavioral Health
Behavioral health-related complaints, grievances, and appeals are reported separately. In SFY05, the PCC Plan's BHP reported receiving 88 complaints, 8 grievances, and 8 appeals filed. The MCO's BHPs reported receiving 10 complaints, 0 grievances, and 69 appeals filed.

Appeals

In SFY05, there were a total of 7,614 eligibility appeal decisions rendered by the Board of Hearings for the Demonstration population. The majority of the appeals, 6,836 or 90%, were closed by dismissal. Approximately 2% were approved, 7% were denied, and 1% were approved in part/denied in part.

X. Safety Net Care Program

In January 2005, the MassHealth Demonstration was approved for a second three-year extension period, from July 1, 2005, through June 30, 2008.

The approval included the establishment of the Safety Net Care Pool (SNCP) for the purpose of reducing the rate of uninsurance. It may be used for expenditures made for the provision of health care services to uninsured individuals and unreimbursed Medicaid costs, through any type of provider (e.g. hospitals, clinics, etc) or through insurance products. Expenditures from the SNCP are subject to the budget neutrality cap.

While the Safety Net Care Pool is established effective July 1, 2005, the new program and products are to be implemented July 1, 2006. The transition year allows the Commonwealth the time necessary for enacting legislation, developing financing and programmatic arrangements, and seeking CMS approval where necessary.. At this writing legislation has been offered by Governor Romney, the state legislature, and health care advocates for sweeping Health Care Reform in Massachusetts that includes proposals for how to implement the Safety Net Care provisions of the Demonstration extension.

In accordance with the Special Term and Conditions of the approved extension, the Commonwealth was required to submit a draft evaluation design on the impact of the Demonstration Project within 120 days of the award of the extension of the Demonstration Project. The design should include 1) a description of the indicators that will be used to measure the rate of uninsurance annually and over the 3 year extension period; 2) a description of the baseline measures that will be used; 3) other indicators as appropriate to demonstrate effectiveness of the SNCP and 4) how the effects of the demonstration will be isolated from those other initiatives occurring in the Commonwealth.

During FY05 MassHealth created a detailed evaluation design for assessing the impact of the three-year extension of the 1115 Demonstration Project on its target populations and submitted it to CMS for approval. The evaluation will be conducted to effectively measure the impact of the MassHealth program on both its waiver eligible populations and the new Safety Net Care population.

Monitoring Changes in the Rate of Uninsurance in Massachusetts:

MassHealth continues to monitor the rate of uninsurance in Massachusetts in order to assess the impact of the Demonstration. Surveys conducted during SFY04 by the Division of Health Care Finance and Policy (DHCFP) and the March 2005 Current Population Survey (CPS) conducted by the Bureau of the Census were compared, as in previous years. It should be noted that differences in design, methodology, and timing of these surveys account for different results. In previous years, while there were

discrepancies between the surveys in the magnitude of the uninsured found in the state, there was concurrence in trends in the rate of uninsurance, which had been moving downward. In 2004, however, both the DHCFP survey and the CPS began to see an increase in the number of uninsured in the state.

Based on DHCFP's 2004 biannual survey, the percentage of uninsured increased by just over half a percentage point (0.7%) from the 2002 survey results, for a total of 7.4%. Children ages 0–18 continued to have the lowest rate of uninsurance at 3.2% (the same rate as reported in 2002), while the percent of uninsured adults increased from 9.2% in 2002 to 10.6% in 2004.

The CPS data reflects the insurance status of individuals during the calendar year prior to the release of the report. In March 2005, the CPS found that the total rate of uninsured individuals in the state had increased to 11.7% in 2004 from 10.7% in 2003. However, the rate of uninsured children decreased from 8.6% to 6.7% between 2003 and 2004. The rate of uninsured adults (ages 19 to 64) increased from 13.7% in 2003 to 15.7% in 2004.

MassHealth will continue to closely monitor changes in the rate of uninsurance in the Commonwealth in order to assess the impact of the new Safety Net Care program from the point of its implementation in July 2006.

Concluding Remarks

Throughout SFY05, the Commonwealth continued the successful implementation of the MassHealth Demonstration Project. This annual report reflects the ongoing creative application of the central strategies of MassHealth to improve access to health insurance for residents of the Commonwealth. Those strategies—expand to uninsured populations; streamline the eligibility process; assist employees in accessing employer-sponsored health insurance; help employers to afford coverage for their employees; provide quality customer service; and effective contracting and oversight of managed care programs—have combined to make SFY05 another successful year for MassHealth.